BRITISH COLUMBIA

Patient Care Quality Review Boards

Annual Report 2011/2012

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Letter to the Minister of Health

June 2012

The Honourable Michael De Jong
Minister of Health
Room 337, Parliament Buildings
Victoria, BC V8V 1X4

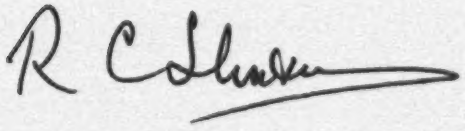
Dear Minister:

It is our pleasure to present the Patient Care Quality Review Board's Annual Report for the period from April 1, 2011 to March 31, 2012. This report has been prepared in accordance with sections 15(1) and 16(1) of the *Patient Care Quality Review Board Act*.

On behalf of the boards, we want to recognize the diligent support of our staff. We also acknowledge the daily dedication of all those health care providers who take responsibility to deliver our quality health care and the commitment of the health authorities to improving care quality in British Columbia. We would also like to thank patients, clients, residents, and their loved ones for bringing their health care concerns to our attention so that we can recommend quality improvement to our system.

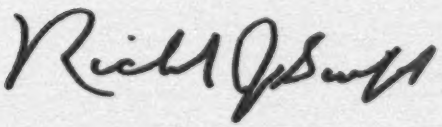
Respectfully submitted,

Dr. John (Jack) H. Chritchley
Chair, Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards



Roger Sharman
Chair, Interior Patient Care Quality Review Board

William Norton
Chair, Northern Patient Care Quality Review Board



Richard J. Swift, Q.C.
Chair, Vancouver Island Patient Care Quality Review Board

Executive Summary

Recommendations

In 2011/12, the Patient Care Quality Review Boards (the boards) reviewed 83 cases and made 109 recommendations for quality improvement. Since the program's inception in 2008, the boards have made 297 recommendations, prompting health authorities to take initiative on a broad range of quality concerns.

Key Recommendation Themes

Communication: The boards reviewed a number of cases where lack of appropriate communication was a recurrent theme. Communication concerns were raised in virtually all care settings by patients, residents and their loved ones. While understanding that the health care professionals' primary role is the provision of health care to patients, clients and residents, the board noted that bridging the communication gaps between patients and their care teams, between care workers and families, and between complainants and the Patient Care Quality Office (PCQO) would improve the overall patient experience.

Falls/Delirium Protocols: The boards reviewed a number of cases this year concerning elderly patients who either fell or developed delirium while in care. The boards stressed the importance of assessing and identifying those patients and residents who are at risk of such conditions and developing appropriate care plans to manage their condition and minimize their risk of injury.

Post-Care Arrangements: The boards noted a number of concerns regarding transition planning at the end of a health care interaction. The boards recommended clearly outlining goals and expectations and ensuring all parties are clear on discharge instructions for patients, including arrangements following discharge from emergency departments and the process for arranging an autopsy.

Conflict Resolution: The boards made several recommendations regarding the need for timely and appropriate conflict resolution, and in some cases third-party mediation, to occur early in the management of a complaint. The boards also noted the importance of staff training to help facilitate awareness of potential conflict and to identify whether additional support is required.

"The boards use the unique patient experience to guide them in making recommendations that strive to improve continuity and quality in the health care system. One of the main themes the boards have identified in their independent reviews is the need for comprehensive patient-centred care plans."

Dr. John H. (Jack) Chritchley,
Board Chair, Fraser, Vancouver Coastal and Provincial Health Services Patient Care Quality Review Boards.

"Thanks for your time and everything you did for us!"

Complainant

Care Quality Improvements

"The Patient Care Quality Review Boards provide a direct link between the patient experience and the patient's ability to influence quality health care. The Interior Patient Care Quality Review Board's recommendations continue to address concerns about communication gaps relating to seniors care and post-care arrangements."

Roger Sharman, *Chair, Interior Patient Care Quality Review Board*

In 2011/12, health authorities continued to work with patients, residents and their loved ones to bridge communication gaps, to ensure appropriate care plans for seniors, to develop thorough patient discharge protocols and to ensure staff is trained on conflict resolution and on identifying contentious situations.

The health authorities met the board's recommendations on improved communication with initiatives such as enhanced patient care conferences, including in-person meetings and sharing detailed care plan information with the patient and families. Health authorities also explored the mechanisms to share patient care plans and considered initiatives to improve communications between care settings.

The boards reviewed a number of cases regarding seniors care; most were about falls and delirium. As a result, the boards encouraged the development of care plans to manage these conditions and to minimize the risk of injury to the patient. A number of facilities were encouraged to review, update, or develop delirium protocol policies.

Additional policies and protocols were refined at the regional and facility levels to enhance the patient experience. This included education and training for staff and tools for communicating about inter-facility transfer arrangements.

The boards made two recommendations to the Minister of Health: one regarding communication about patient transfer and another about non-resident billing practices. In response, the Ministry of Health instructed each health authority to adopt a process ensuring patients and their families understand the patient transfer process and its implications. As well, the Ministry of Health continues to encourage improved consistency and transparency around non-resident billing processes.

"I do wish to thank everyone who reviewed my file for their efforts and for their time spent on this review."

Complainant

Introduction

In May 2008, the provincial government introduced the *Patient Care Quality Review Board Act* (the Act), which established a clear, consistent, timely, and transparent patient complaints process in British Columbia.

Each health authority was required to establish a central Patient Care Quality Office (PCQO) to receive and respond to patient concerns. PCQOs formally register, track, respond to, and report on patient concerns.

The Act also established six Patient Care Quality Review Boards (the boards) – one aligned with each health authority. Independent from the health authorities and accountable to the Minister of Health, the boards review patient care quality complaints that have first been addressed, but not resolved, by a health authority's PCQO.

After completing a review, the boards may make recommendations to the health authority and/or the Minister of Health for care quality improvement and to improve the complaints process itself.

1

Local level complaints resolution

Patient complaints are best resolved at the time and place they occur. Patients and their loved ones are encouraged to first speak with the person who provided the service.

2

Patient Care Quality Offices

If patients are unable to resolve their complaints at the time of service, or they wish to make a formal complaint, they can contact the PCQO for their region (see Further Information, p.56).

3

Patient Care Quality Review Boards

If patients are not satisfied with the response from the PCQO, or with how their complaint was handled, they can request a review by an independent Patient Care Quality Review Board.

Patient Care Quality Office

"The independence of the boards, their freedom from influence by health authorities and government, gives their recommendations credibility in the eyes of the complainants. It is rewarding for the boards to see that the health authorities take their recommendations seriously. Adopting the board's recommendations affirms the purpose and the success of this structure."

Richard J. Swift, *Q.C.*
Chair, Vancouver Island Patient Care Quality Review Board

Mandate

The *Patient Care Quality Review Board Act* and External Complaint Regulation govern how the boards review complaints and what can and cannot be reviewed.

The boards may review any care quality complaint regarding services funded or provided by a health authority, either directly or through a contracted agency. The boards may also review complaints regarding services expected, but not delivered, by a health authority (for example, a complaint regarding a cancelled surgery).

The boards may only review complaints that have first been addressed by a health authority's Patient Care Quality Office, unless otherwise directed by the minister.

If the boards receive a complaint that cannot be reviewed, the complainant is redirected to the most appropriate body for their concerns.

As a result of a review, the boards can make recommendations to a health authority or to the minister to improve the way complaints are handled, to improve the quality of patient care, or to resolve a specific care quality complaint.

Finally, the boards monitor, track, and report on care quality complaints in British Columbia.

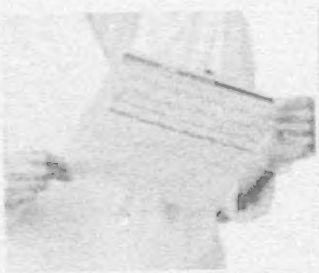
The Review Process

Patients and their loved ones may request a review by submitting a review request form (by mail, e-mail, or fax), or by calling 1 866 952-2448. If the board can review the complaint, the health authority's Patient Care Quality Office will be notified and asked to provide a copy of any information relating to the complaint.

The board will review the facts and other background information, seeking expert advice and/or clarification from the health authority, the complainant, and/or other experts, as required.

Once the review is complete, the board will send the complainant and the health authority a final decision letter, indicating whether any recommendations have been made. The boards explain their findings and the reasoning for decisions in the letter. A copy of the letter is also sent to the Minister of Health so the ministry can follow up with the health authority on the implementation of recommendations.

When a board makes recommendations, the health authority will contact the complainant to discuss the outcome and any actions that may be taken to address the care quality issues highlighted by the board's review.



About the Boards | *Current Members*

Board members are appointed by the minister based on their expertise and experience. Members are eligible to serve terms of no more than two years, and may be reappointed to consecutive terms at the discretion of the minister. Current health authority employees, board members, and contractors are not eligible to serve on the boards.

The boards would like to acknowledge the contribution of Gerald Zimmerman to the Interior Patient Care Quality Review Board this year. Gerald left the board earlier this year.

The boards are deeply saddened by the passing of Vancouver Island Board member Graham Alce this year. Graham played a tremendous role on the board and will be truly missed.

Fraser/Vancouver Coastal/Provincial Health Services Patient Care Quality Review Board

Dr. John (Jack) H. Chritchley, Chair
Dr. John H. V. Gilbert
Robert D. Holmes
Sandra Wilking
Dr. Naznin Virji-Babul
Janis A. Volker

Interior Patient Care Quality Review Board

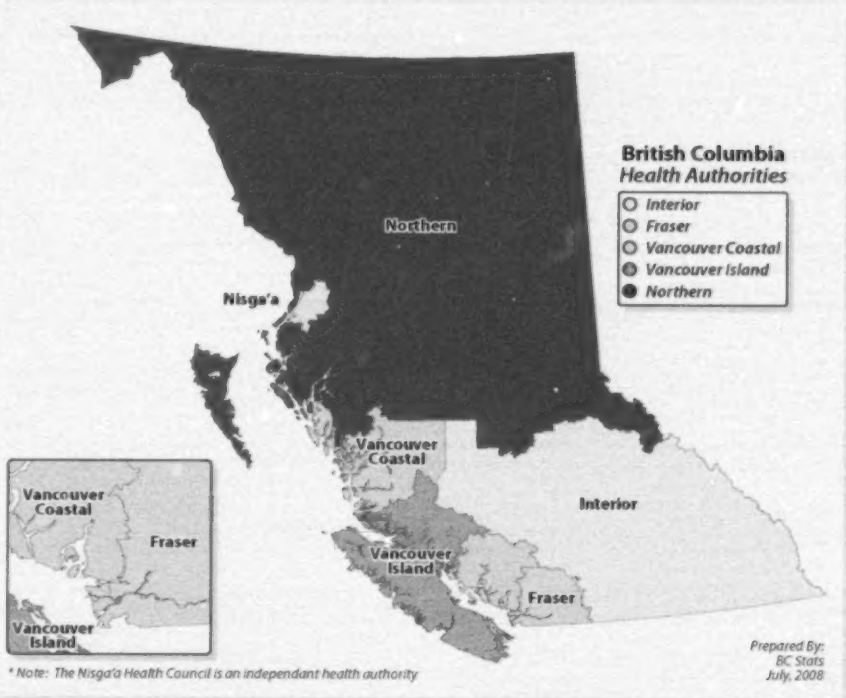
Roger Sharman, Chair
Dr. Randall Fairey
Donna Horning
Thomas Humphries
Gloria Morgan
Dr. Robert Ross

Northern Patient Care Quality Review Board

William Norton, Chair
Dr. John (Jack) H. Chritchley
Lorna Dittmar
Elizabeth MacRitchie
Allison Read

Vancouver Island Patient Care Quality Review Board

Richard J. Swift, Q.C., Chair
Ann Beamish
Michael F. Patterson
Dr. Linda J.A. Thomson



* Note: The Nisga'a Health Council is an independant health authority

"The Northern Patient Care Quality Review Board serves more than two-thirds of B.C.'s landscape. Despite its unique demographic, the Northern board's recommendations were similar to other areas of the province. The board's recommendations focussed on improving unmet expectations between patients, families and health care providers."

William Norton
Board Chair, Northern Patient Care Quality Review Board

Achievements

The *Patient Care Quality Review Board Act* has established a clear, consistent, timely and transparent process for addressing care quality concerns. This process is an avenue, independent of the health authorities, for patients to share concerns on their health care experience. Using the patient experience as a measure of quality health care, this process strives to ensure that the health care system is responsive to those patient voices.

The boards continue to manage complaint reviews through a standard process guided by best practices outlined in the document *Best Practices in Complaints Investigations* (See Appendix C). The document provides guidelines to ensure complaints investigations are confidential, ethical, fair, thorough and transparent.

In 2011/12, the boards made a total of 107 recommendations to the health authorities, with 84 (79 per cent) of those recommendations to improve the quality of patient care and 23 (21 per cent) to improve the complaints process. Each review was an opportunity for the boards to understand the patient experience, to recommend quality improvements, and to safeguard the crucial relationship between patients, their care providers, and the health care system.

This year, the boards continued to make recommendations to encourage bridging the communication gap between patients and their care teams and between care workers and families. Health authorities have responded to these recommendations by refining policies to ensure care conferences are arranged with patients and their families to provide more information and, if necessary, to explain care updates.

A further response to board recommendations includes developing a protocol where nurses assigned to patients waiting in the hospital for a surgery or procedure are updated on the status of any waits. This allows the nurse to inform the patient of any delays or wait times and further closes the communication gap between the patient and their care team.

The patient discharge process was also refined so that all documents provided to families during the intake meeting clearly outline goals and expectations upon discharge and are in writing and signed by the parties.

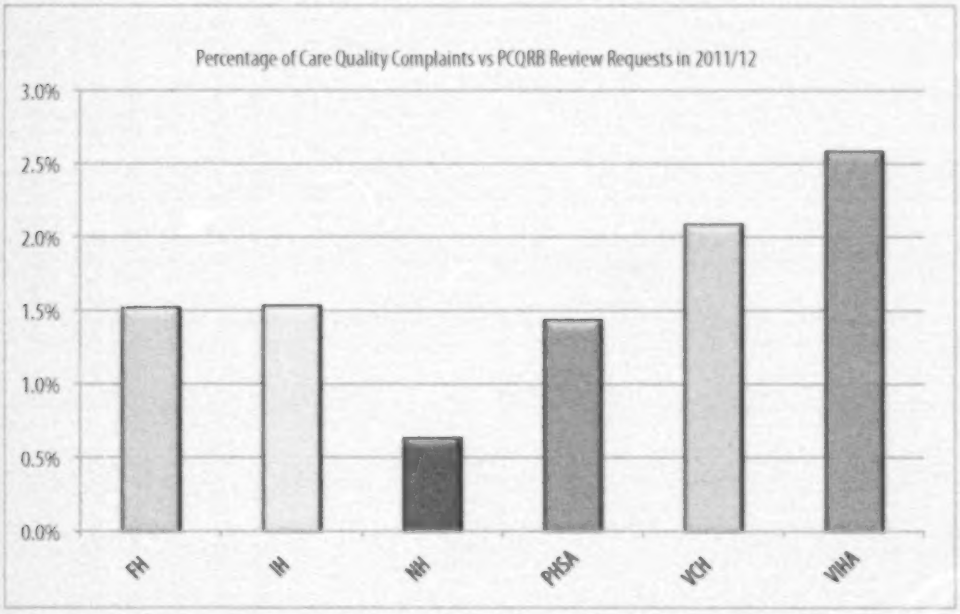
Statistical Overview | *Patient Care Quality Offices*

The boards collect data from the health authority Patient Care Quality Offices (PCQOs) regarding the number and type of complaints received by the PCQOs in each quarter throughout the fiscal year. In 2011/12, there were 5,083 care quality complaints (a decrease of 406, or 7.4 per cent, from the 5,489 complaints received in 2010/11), 192 external complaints[1] and 3,303 inquiries in British Columbia (see Appendix A for details). The table below presents the volume of care quality complaints received by each PCQO between April 1, 2011 and March 31, 2012.

Table 1: Volume of Care Quality Complaints by Health Authority and B.C.

	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total 2011/12
Fraser Health	487	476	373	376	**1,712**
Interior Health	228	227	236	288	**979**
Vancouver Coastal Health	235	321	262	332	**1,150**
Vancouver Island Health Authority	158	155	198	224	**735**
Northern Health	58	38	34	28	**158**
Provincial Health Services Authority	88	67	93	101	**349**
British Columbia	**1,254**	**1,284**	**1,196**	**1,349**	**5,083**

Of the 5,083 care quality complaints received by PCQOs this year, only 1.7 per cent proceeded to the boards for review – suggesting that the vast majority of complaints are resolved at the health authority level. The chart below shows the percentage of care quality complaints that escalated to the boards from each PCQO over the 2011/12 period.



1 External complaints are defined by the *Patient Care Quality Review Board Act* and External Complaint Regulation, and may include complaints about services that are not funded or provided by the health authorities, or complaints that are best addressed by another entity.

The boards may only review complaints that have first been addressed by the health authority's Patient Care Quality Office (PCQO), unless otherwise directed by the Minister of Health. In 2011/12, the boards accepted 90 review requests (all of which had been through the PCQO process), completed 83 reviews, and cancelled three reviews at the request of the complainant. This represents a 23 per cent increase in reviews accepted, and a 51 per cent increase in reviews completed over 2010/11.

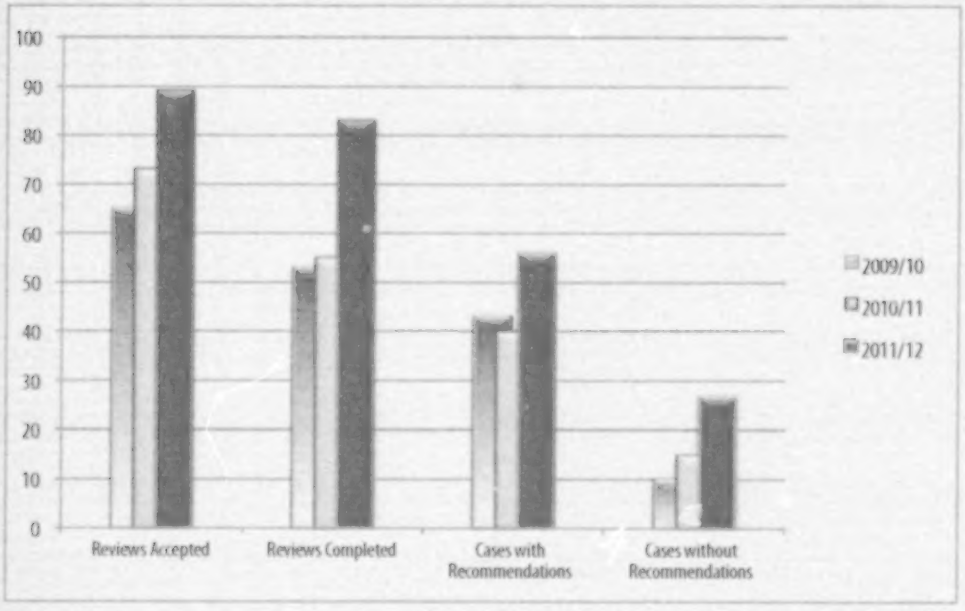
In 56 of the completed reviews (67 per cent), the boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself. In 27 of the completed reviews (33 per cent), the boards did not make recommendations, having found, for example, that the care provided had been satisfactory or that the circumstances of the complaint did not present an opportunity for care quality improvement. The table below presents an overview of the boards' volume by health authority.

Table 2: Overview of Patient Care Quality Review Board Volume

	Reviews Accepted	Reviews Completed	Cases with Recommendation(s)	Cases without Recommendation(s)
Fraser Health	26	20	14	6
Interior Health	15	19	13	6
Northern Health	1	3	3	0
Provincial Health Services Authority	5	3	3	0
Vancouver Coastal Health	24	17	11	6
Vancouver Island Health Authority	19	21	12	9
Total	**90**	**83**	**56**	**27**

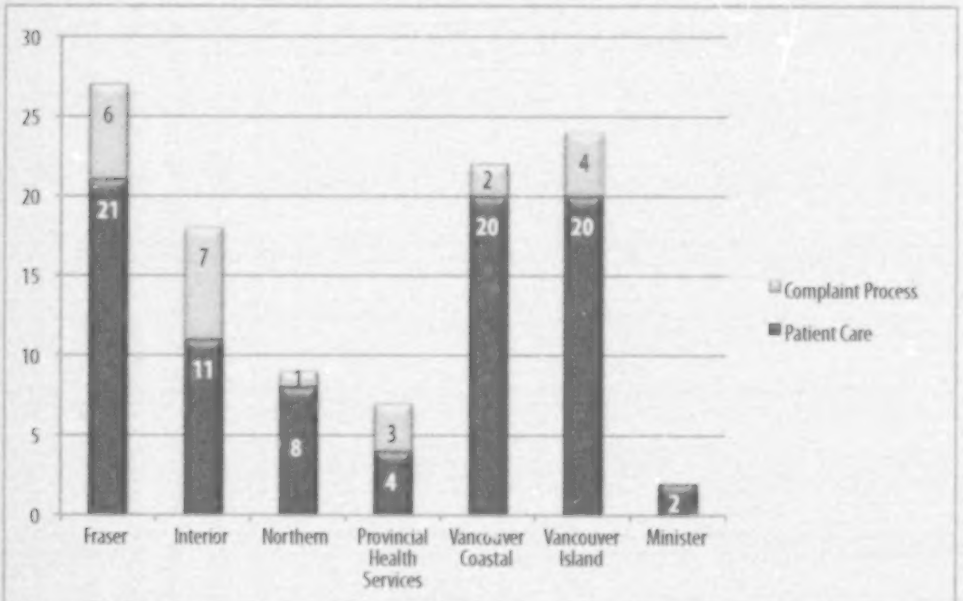
The boards made a total of 109 recommendations in 2011/12 – 107 to the health authorities and two to the Minister of Health. The boards accepted and completed more reviews than last period, resulting in more recommendations for care quality improvement (see chart below for volume comparison).

Chart 1: Volume Comparison for Recommendations and Reviews



Of the 107 total recommendations to health authorities, 84 were to improve the quality of patient care, and 23 were to improve the complaints process (see chart below). In 21 of the completed reviews, the boards identified opportunities for the Patient Care Quality Offices (PCQOs) to improve the quality of their investigation or response; in the remaining 62 reviews, the boards found the PCQOs had responded appropriately.

Chart 2: Recommendations Concerning Complaints Process vs. Patient Care



The boards also collect information regarding the timeliness of health authority responses to board recommendations. Under the Patient Care Quality Review Board Act, health authorities are required to respond to recommendations within 30 business days. Health authorities achieved this timeline in 47 of the 56 reviews that resulted in recommendations (84 per cent).

Finally, the boards track the timeliness of our own reviews. Under the legislation, the boards are expected to complete those reviews and respond within a maximum of 130 business days. In 11 cases (13 per cent), the boards exceeded this timeline. (e.g. to obtain an independent medical opinion, or to obtain additional information). In only one case the boards exceeded 133 business days and informed the parties involved.

The chart below represents the subjects of all the complaints reviewed by the boards in 2011/12.[2] Because the category for "Care" is quite general, and the population accessing acute care services quite large, care quality complaints are often concentrated under "Acute Care – Care." Note that one complaint may encompass more than one care issue, so the total number of care issues will often be higher than the total number of complaints reviewed.

Sector — Care Issue		Sector — Care Issue	
Acute Care (excl. MHA) – Care	60	Mental Health & Substance Use – Communication	2
Acute Care (excl. MHA) – Communication	12	Acute Care (excl. MHA) – Administrative Fairness	1
Emergency Care – Care	12	Acute Care (excl. MHA) – Safety/Secure Setting	1
Ambulatory Care – Care	11	Acute Care (excl. MHA) – Supplies/Equipment	1
Acute Care (excl. MHA) – Accessibility	10	Acute Care – Cardiac – Care	1
Acute Care (excl. MHA) – Attitude/Conduct	10	Administration – Administrative Fairness	1
Home & Community Care – Care	7	Ambulatory Care – Coordination	1
Home & Community Care – Accessibility	6	Ambulatory Care – Cancer – Care	1
Mental Health & Substance Use – Care	6	Ambulatory Care – Cancer – Access	1
Ambulatory Care – Accessibility	5	Ambulatory Care – Cancer – Other	1
Emergency Care – Attitude/Conduct	5	Emergency Care – Coordination	1
Acute Care (excl. MHA) – Discharge Arrangements	4	Emergency Care – Accessibility	1
Acute Care (excl. MHA) – Financial	3	Emergency Care – Environment	1
Ambulatory Care – Communication	3	Home & Community Care – Supplies/Equipment	1
Emergency Care – Discharge Arrangements	3	Home & Community Care – Attitude/Conduct	1
Home & Community Care – Administrative Fairness	3	Home & Community Care – Communication	1
Mental Health & Substance Use – Accessibility	3	Home & Community Care – Financial	1
Mental Health & Substance Use – Attitude/Conduct	3	Mental Health & Substance Use – Safety/Secure Setting	1
Residential Care – Care	3	Mental Health & Substance Use – Discharge Arrangements	1
Acute Care (excl. MHA) – Environment	2	Mental Health & Substance Use – Accommodation	1
Acute Care (excl. MHA) – Lost Article	2	Mental Health & Substance Use – Environment	1
Ambulatory Care – Attitude/Conduct	2	Residential Care – Bill of Rights	1
Ambulatory Care – Safety/Secure Setting	2	**TOTAL**	**200**

2 Note that the Acute Care category excludes Mental Health and Addictions (MHA) because MHA is its own separate category.

Recommendations and Responses | *Minister of Health*

After completing a review, a board may make recommendations to the health authority and/or the Minister of Health to improve the quality of care and to improve the complaints process.

When making recommendations, the boards consider:

- The context of the complaint from both the health authority and the patient's perspective;
- The policies, procedures, guidelines, etc. that are applicable to the complaint;
- The feasibility of implementing the recommendation;
- The potential impact of the recommendation; and
- The evidence base for the recommendation.

The health authorities carefully consider recommendations and are required to respond within 30 business days to indicate what action(s) will be taken to address them.

In 2011/12, the boards made two recommendations to the minister and 107 to the health authorities. The following presents each of the boards' recommendations for this reporting period, along with some highlights of actions taken in response.

Recommendations to the Minister of Health

1. That the Minister of Health consider directing all health authorities to adopt an information package similar to the one used by Interior Health on inter-facility transfers, and develop a process for ensuring patients and/or their families receive this information. The information should include a comment regarding the financial implications should the patient die while in care following a transfer.

   Summary of Response:
   In response to the recommendation, the Ministry of Health instructed each health authority to create or update inter-facility transfer print materials with the requisite information, and to implement a formal process for providing the materials to patients and/or their families. This request was facilitated through the Patient Care Quality Working Group.

2. That the Minister of Health ask staff to review the Non-Resident of Canada Agreements, Visitor Rates, Visitor Rate Sheets, and any written scripts used to describe these items to ensure that they are standardized across the health authorities and that Non-Resident of Canada Agreements and Visitor Rate Sheets are available in a number of different languages across the province.

   Summary of Response:
   The materials relating to non-resident of Canada billing submitted by health authorities will be shared with the Chief Financial Officers Committee to raise awareness of the degree of variation in these materials across the province. The Ministry of Health will continue to monitor health authority practices and performance in this area, and encourage health authorities to improve consistency and transparency in billing practices for non-resident of Canada patients under the terms of the existing policy.

Fraser Health (FH) – Recommendations and Responses

- FH is responsible for serving a densely populated region with more than 1.6 million British Columbians.
- The board reviewed 20 cases from FH in 2011/12, resulting in 27 recommendations. Of those recommendations, 21 were for care quality improvement, while six were to improve the complaints process.
- Many of our recommendations to FH have focussed on issues of communication—between patients and their care teams, between care workers and families, and between complainants and the Patient Care Quality Office (PCQO). In response, FH has arranged care conferences with patients, provided further information (such as more timely and comprehensive explanations to complainants), and arranged educational offerings for staff.

1. Complaint about the cessation of home wound care services

Recommendation:

i. That FH have home care staff confer with the family physician to determine whether or not the client is capable of providing their own wound care and if not, determine whether, in the physician's opinion, there should be ongoing follow-up care, including accessing home wound care services.

Summary of Response:

i. The manager of home health contacted [the complainant] to set up a meeting, but [the complainant] called to say they were going away and would call again when they returned. Home health manager has called and left messages but there has been no contact for three weeks (as of [date]). A letter has been sent providing PCQO number if [the complainant] wants further follow-up.

2. Complaint regarding patient's diagnosis of Fetal Alcohol Spectrum Disorder and disagreement regarding administration of specific medication

Recommendation:

i. That FH review this matter with a view to ensuring that the provision of medication aligns with the consent provided by the patient, the substitute decision maker, or applicable legislation.

ii. That FH provide an explanation for the diagnosis of Fetal Alcohol Spectrum Disorder (FASD) and identify when this diagnosis was made and by whom.

Summary of Response:

i. Because FH's electronic health system does not offer a way of flagging files for unwanted medication, a bright yellow note will be used on the patient's file to indicate that the medication should not be given.

ii. In response to this recommendation, a psychiatrist rescinded the FASD diagnosis for this patient.

3. Complaint about alleged improper administration of tetanus injection

Recommendation:

i. In future similar matters, the PCQO ensure that all care quality concerns have been reviewed, investigated and communicated to the complainant directly, prior to closing the matter and referring the complainant to the board.

Summary of Response:

i. The roles and responsibilities of the patient care quality officer have been discussed and implemented as identified in the recommendation and in accordance with the *Patient Care Quality Review Board Act.*

4. Complaint regarding lack of notification about patient falls and transfer, loss of personal items, and lack of PCQO response

Recommendation:

i. That when an adverse event warrants an entry in the Patient Safety Learning System (PSLS), the patient's family should be notified of the event promptly.

ii. That FH ensure that when a complaint is received by the PCQO that the office clearly communicate to the complainant when the file is resolved and closed, either in writing or by telephone.

iii. That FH review the charting relating to this matter with a view to ensuring that staff are aware of the requirements for appropriate charting in both the Medical Unit and the Patient Assessment and Transition Home Unit, and to ensure that the charting is appropriate, avoids duplication, and ensures continuity of care.

iv. That FH, after a reasonable length of time, evaluates the S.A.F.E. Universal Fall Precautions program (implemented October 2010) for effectiveness, and that the health authority report to the board on their findings after such time.

Summary of Response:

i. Entry into PSLS is not dependent on "an adverse event warranting reporting" and is therefore not sufficient for disclosure in itself. Disclosure is based on an assessment of harm as per FH policy. If there is harm to the patient, disclosure to the patient must occur. Disclosure to the family occurs with patient consent or if a patient is incapable. In this case, disclosure did not occur on a timely basis. This has been reviewed with staff.

ii. The process has been revised to ensure that when the PCQO has resolved and closed a file, communication is provided either in writing or by phone.

iii. Regional medical clinical nurse educators (RMCNE) will review documentation standards with staff. Specific forms for charting will be discussed at the Medicine Program Documentation Working Group and RMCNE Working Group meetings.

iv. There was a review of the S.A.F.E. program and a presentation to the Health Operations Committee in June 2011.

5. Complaint regarding a requested autopsy that was not completed prior to cremation

Recommendation:

i. That FH creates a procedure to ensure that critically ill patients at [acute care facility] are assessed and treated with an appropriate sense of urgency.

ii. That FH review this matter to ensure that, when necessary, health care staff at [acute care facility] request an inpatient's medical records when they have recently received care from another facility or health authority.

iii. That FH revise their rules, policies, procedures and forms that pertain to autopsies to ensure that the process is clear to all parties concerned, with particular attention to clarifying the process for the personal representatves and next of kin of the deceased person.

iv. That FH PCQO ensures their office has reviewed, investigated and communicated directly and empathetically with the complainant prior to closing their complaint file and referring the complainant to the Fraser Patient Care Quality Review Board.

Summary of Response:

i. FH critical care program and the medicine and surgical program are developing a procedure and supporting tools to ensure critically ill patients are assessed and treated with an appropriate sense of urgency across FH. They have also established an outreach program which identifies a process for the rapid response team (based on a pilot at other facilities).

ii. FH sent a memo to physicians and internists to remind them to get medical records in September 2011.

iii. FH patient registration services will develop patient education materials and FH will review the existing materials.

iv. FH PCQO reviewed the recommendation with patient care quality officers in August 2011.

6. Complaint that a patient was given a vaccination against parental consent during a school immunization clinic

Recommendation:

i. That FH confirms the implementation of the corrective actions imposed throughout the public health immunization clinics in the health authority.

Summary of Response:

i. FH re-iterated the measures they had taken on [date]:

- *a.* Stopping the practice of splitting consent and immunization based on a discussion at the Public Health Leadership meeting.
- *b.* Circulating the guidance document "Best Practices: Mass Immunization Clinics" to all front-line staff.
- *c.* Managers addressing the "seven rights of medication administration" during staff meetings.
- *d.* Providing all nurses with an education update on vaccine incident management and reporting.

7. Complaint regarding FH refusal to participate in wound care treatment desired by complainant

Recommendation:

i. The board recommends that in the future FH consider employing alternate dispute resolution to mediate concerns between family members and health care providers when cases of conflict arise regarding treatment and initial attempts at resolution fail.

Summary of Response:

i. FH has a medical director at each residential care facility, whose role includes the review of concerns regarding health care services and assisting with differences in clinical opinion regarding appropriate treatment. Part of this role will be engaging residents, families, and the health care team in discussion to resolve areas of conflict. The program medical director can be called upon for additional support.

FH residential care and assisted living is also developing an ethical framework for decision making, which is designed to assist with reviewing difficult clinical decisions.

8. Complaint regarding the presence of a food item on hospital bed, bruising on arms, and staff attitude towards the complaint following surgery

Recommendation:

i. That FH take measures to ensure that the "no food" standard of practice is strictly enforced in order to prevent a recurrence of this event (e.g., promote the use of the Patient Safety and Learning System [PSLS] as a tool to report contraventions in practice standards).

ii. That FH further educates its staff with respect to the expectation for respectful communications with patients and their family.

Summary of Response:

i. The standards were reviewed with staff, who report contraventions of practice standards and policies through PSLS and direct reporting to managers. A review of the signage reminding people that food is not allowed in the OR will be completed in fall 2011 to identify opportunities for improvement. Random audits will be done by managers to ensure compliance.

ii. Staff were interviewed during the investigation and respectful communication was stressed. The incident was used for education regarding patients' perceptions of feeling disrespected.

9. Complaint about inadequate diagnosis of a heart problem, conflict of interest in health authority investigation and unprofessional staff comments

Recommendation:

i. That a PCQO representative be present at any discussions involving the complainant, including those between the designated lead and complainant.

ii. That the PCQO representative discuss the investigation process with a designated lead before the designated lead discusses the complaint with the complainant.

Summary of Response:

i. It is the current practice of the PCQO to have a representative at meetings involving the complainant. Each complaint is assessed individually with regard to the need for the PCQO representative to coordinate teleconferences between designated leads and the complainant in order to facilitate a satisfactory outcome for the complainant. The patient care quality officers will continue to endeavour to consistently provide the best support and coordination possible within existing health authority resources.

ii. It is also the current practice of the PCQO to confer with the designated lead regarding the investigation prior to discussion with the complainant. In follow-up to the board's recommendation, the process has been reviewed with the patient care quality officers to promote consistency in practice

10. Complaint about the delay for surgical procedure

Recommendation:

i. That FH provide a detailed explanation to the complainant as to why the surgical procedure was not done when the patient arrived at [acute care facility] on [date].

ii. That FH:

a. Review the adult orthopaedic level 3 transfer policy to specify and define what the requirements and obligations of receiving hospitals are;

b. Ensure that the revised policy and forms require confirmation and recording by receiving hospitals, that they are able to receive patients and complete required surgical procedures in a timely way, and

c. Report back to the board and the minister on changes made once the revised policy is established and again on the effectiveness of those changes after a reasonable amount of time but no longer than 24 months.

Summary of Response:

i. FH's PCQO will send the complainant a letter explaining the scheduling of [the patient's] surgery on [date].

ii. FH is currently reviewing the policy. They will report to the board and the minister on changes made to the policy and the effectiveness of those changes in December 2013.

11. Complaint about care received, doctors orders not followed and poor staff attitude

Recommendation:

i. The board recommends that the health authority review this matter with a view to having formal care plans for all hospitalized patients and, where feasible, having the care plan be developed by a multidisciplinary team in conjunction with appropriate discussions with the patient and family.

ii. The board recommends that the health authority explain to families and patients why the moves from different locations and wards within the hospital are required. In this case the board recommends that the health authority explain to the family the necessity for moving [the patient] eight times during their hospital stay and whether these moves affected the continuity of care in any significant respect.

Summary of Response:

i. FH currently develops interdisciplinary care plans for each patient in conjunction with interdisciplinary teams. Patients and families are able to give into the development of the care plans through interaction with the care team. Tools to support development of care plans include kardexes (FH included an example in response package). Kardexes currently do not become part of the medical record on discharge. FH is considering having a consolidated interdisciplinary care planning tool become part of the health care record, as well as creating electronic care planning tools. FH is also in the process of developing a standardized transfer of information for staff, patients, and families in compliance with Accreditation Canada standards.

ii. Generally, the reasons for moving patients are explained to patients and families verbally at the time of the move. These verbal explanations may not be included in the patient record.

A letter has been sent to the family explaining the necessity of the moves that occurred in this case.

12. Complaint about wait time and no physician in Emergency Department

Recommendation:

i. That FH have the emergency department triage nurse communicate the essential information that can be found in the brochure "You Have an Emergency...Then You Are Asked To Wait" to patients and ensure by direct communication that patients have understood the information.

ii. That FH respond to [the complainant] and provide answers to the complainant's questions and confirm whether or not there was a doctor available in the emergency department the evening the complainant attended [acute care facility].

Summary of Response:

i. The pamphlet is available for patients in all 12 of FH's emergency departments. However, the information is not individually reviewed with each patient due to time and resource challenges. The brochure is intended as an explanation of emergency department processes.

ii. The letter has been sent to the complainant.

13. Complaint about family not being involved in end-of-life decisions

Recommendation:

i. That FH improve the process of ensuring that patients and their families understand the health status, care plans, transfer policies, and what palliative measures only and do not resuscitate mean. When English is not the patient's or family's first language, the health authority should consider involving a qualified medical health interpreter to explain the care plans to the patient and family.

Summary of Response:

i. FH supports the standard practice that when a patient or family member and a health care professional do not speak the same language, an appropriately trained interpreter will be called so that services can be delivered in a linguistically appropriate and culturally sensitive manner. For professional interpretation needs, FH accesses the Provincial Language Service, an agency of the Provincial Health Services Authority that has capability to provide spoken language interpreting services in over 150 languages.

ii. In this case, this was demonstrated through the involvement of an interpreter in several meetings with family members. In these meetings, professional interpretation assisted [acute care facility] staff to communicate the following information to family members:

- the meaning of Palliative Measures Only (PMO) orders,
- reasons for a Do Not Resuscitate (ONR) order,
- to provide update on the patient's prognosis, and
- social work support for the family.

14. Complaint about negligent care and no autopsy performed

Recommendation:

i. The board recommends that the health authority ensure that in cases where it appears there may have been a significant adverse event(s) that resulted in death and where the coroner is involved, that the family be notified that if neither the coroner, or the physicians involved determine that an autopsy is required, that

a. The family be notified that an autopsy is not deemed to be necessary for the purposes of the coroner or the physicians involved and will not be performed at their direction; and,

b. The family is notified that they may request that an autopsy be performed at the family's expense.

ii. The board recommends that the health authority provide an update to the family and the board about the progress in implementing the recommendations of the Medicine Program Quality Review Committee regarding this matter.

Summary of Response:

i. Current practice in FH is that when a hospital death has occurred, an autopsy can be requested by a coroner or a physician. This includes the emergency department physician, the patient's family physician or any other physician who may have attended to the patient during their hospital stay. In cases where the attending physician or the coroner has not requested an autopsy, the legal next of kin may ask a physician to request an autopsy. The pathologist who performs autopsies has the right to refuse if he/she believes that an autopsy is not warranted.

ii. FH is aware of the issues surrounding private pay autopsies. Discussions are underway in pathology and laboratory medicine to develop a more formal policy with respect to private pay autopsies.

iii. The board and the complainant with a status update on each recommendation of the Medicine Program Quality Review Committee.

Interior Health (IH) – Recommendations and Responses

- IH is responsible for a broad geographic area including both larger cities and rural communities, with a population of more than 742,000 people.
- The board reviewed 19 cases from IH in 2011/12, resulting in 18 recommendations. Of those recommendations, 11 were for care quality improvement, while seven were to improve the expediency of the Patient Care Quality Office complaints process.
- Many of the board's recommendations to IH focussed on communication. For example, recommending that the health authority develop a protocol wherein nurses assigned to patients waiting in the hospital for a surgery or procedure be provided an update on the status of any waits.
- In response to the recommendations IH prioritized improving efforts to communicate to complainants with detailed answers, offering in-person meetings and clearly communicating who the most responsible physician is to the patients and families. They also recently developed a clinical practice standard regarding OR patient postponement which will include language to promote communication from nursing staff to the patient.

1. Complaint regarding wait-time for surgery for appendicitis

Recommendation:

i. That IH provide a written response to the complainant's questions that it is able to answer, schedule an in-person meeting with the complainant to discuss any outstanding questions, and encourage the complainant to bring a third-party (a friend, family member or advocate) to the meeting for support.

Summary of Response:

i. Patient care quality officer for [acute care facility] has initiated correspondence to the complainant, and will make an offer to hold a meeting.

2. Complaint regarding wait-time for bone scan

Recommendation:

i. That IH investigate opportunities to upgrade its current manual appointment-booking procedure to an electronic system, and, if feasible, adopt that system.

ii. That IH consider changing the [acute care facility] diagnostic imaging booking process so that patients are offered alternative dates when scheduling appointments.

Summary of Response:

i. IH has an electronic booking system for diagnostic imaging, but finds it more efficient to use its current manual appointment booking procedure.

ii. IH stated that alternative dates are offered when booking routine appointments, but in this case they were calling the complainant about an appointment becoming available because someone had cancelled. IH stated that, in cases such as this, alternative times are not offered.

3. Complaint about lack of assessment at ER and difficulty accessing services

Recommendation:

i. That IH review this matter with a view to ensuring that when a patient presents for triage at an ER, such as the [acute care facility] in [city], that the presentation and interaction is documented.

Summary of Response:

i. Identified and addressed the gap in documentation.

4. Alleged negligent care at residential facility, lack of communication from staff, and dispute over re-admission to facility

Recommendation:

i. That IH have [residential care facility] administration meet with the complainant to update the resident's care plan.

Summary of Response:

i. Management at [residential care facility] has met with [the complainant] to review the care plan. [The patient] was discharged into the care of [the complainant] and remains at home with support from IH home and community care.

5. Complaint about the lack of treatment for a suspected urinary tract infection, which the complainant feels led to the patient's delirium, fall, decline, and death

Recommendation:

i. That IH review their current draft delirium protocol, and ensure that when implemented it will take into consideration high-risk elderly patients and apply an appropriate treatment protocol to them specifically (e.g. consultation with a geriatrician).

Summary of Response:

i. The delirium protocol remains a draft document thus there is opportunity for IH to incorporate the recommendation from the board. The recommendation has been shared with the IH's Professional Practice Office where responsibility for the Clinical Decision Support Tools rests.

6. Complaint about emergency department staff failing to recognize the patient's stroke symptoms and missed medication during hospital admission

Recommendation:

i. That IH provide the complainant with a detailed list of actions that have been taken in response to this case, outcomes that have been achieved since the new actions were put in place, and measures that have been instituted.

Summary of Response:

i. A detailed list of actions that have been taken in response to this case, outcomes that have been achieved since the new actions were put in place, and measures that have been instituted was mailed to the complainant.

7. Complaint that the patient was misdiagnosed, should have received a CT scan and a toxicology test and that the hospital did not properly cooperate with the investigation

Recommendation:

i. That IH share with the family the results of the chart review as well as the Interior Health Quality Improvement Review and outcomes of the recommendations which were made.

ii. That IH remind all hospitals of the role of the Patient Care Quality Office (PCQO) and ensure that the PCQO is involved from the beginning of future cases.

Summary of Response:

i. The chart review, final report of the quality review and the quality review recommendations will be sent to the family.

ii. IH has committed to work with IH Communications to ensure that the presence and mandate of the PCQO is well known and understood across the health authority.

An ad for the PCQO will be created for the internal IH website, and it will refresh each time a browser is opened.

A summary of the mandate of the PCQO will be sent to IH staff via the weekly update email sent to staff, and will also appear on the homepage of the internal IH website.

8. Complaint regarding wait time for colonoscopy

Recommendation:

i. The board recommends that IH develop a protocol wherein nurses assigned to patients waiting in hospital for a surgery or procedure be required to provide their patients with an update, when appropriate, every hour about the status of their surgery or procedure and about any delays that the patient may experience.

Summary of Response:

i. IH has recently developed a clinical practice standard regarding OR patient postponements. The draft will continue to be revised to include language that will promote communication from nursing staff to the patient.

OR managers across IH will also adopt signage in their waiting areas that will have consistent wording that will speak to waiting patients' order of urgency and encourage patients to communicate with staff prior to leaving the waiting area should their procedure be cancelled. This signage will be shared with IH managers of ambulatory care as well.

9. Complaint that colonoscopy was performed violently and without sedative. Response from hospital staff was not empathetic.

Recommendation:

i. That IH ensure that when a response to a complaint is provided by a department head, such as the chief of staff in this case, that the response only be provided once he/she has discussed the matter with all staff involved (i.e. doctor, nurses) and not solely rely on a review of the documentation.

ii. That the Patient Care Quality Office (PCQO) interview the nurse involved in the procedure for the nurse's perspective on what transpired and to ascertain why there was no documentation on the care provided, and determine whether further response to the complainant is required.

Summary of Response:

i. The PCQO will review investigations completed by medical staff members and address any gaps. The PCQO will also include the details of physician's investigations in their response letters.

ii. IH advised that the nurse was, in fact, interviewed at the time of the review, but could not remember any details about the event. They will report changes implemented as a result of this case to the complainant, which include:

- Reinforcing the process for verifying consent by specifically communicating to the patient that their sedation will be conscious, rather than general anaesthetic. Patients will be sleepy, but able to respond to and obey commands. Cramps may be experienced, but patients can let their nurse know if they are uncomfortable.
- Charting very accurately the time sedation medication is administered along with the name of the medication and dosages ordered by physicians.
- Implementing a pain assessment tool using an institutionally approved pain scale to identify area, duration, and type of pain.

10. Complaint about alleged discrimination and denial of mental health services

Recommendation:

i. That an attempt be made to organize another meeting to determine whether a referral to the Canadian Mental Health Association (CMHA) would be appropriate for [the complainants]. The meeting participants should include: [the complainants], Vernon mental health representatives, as well as an advocate for [the complainants], such as a case manager or other health professional, and a mediator agreed to by both parties. The purpose of the meeting should be clearly communicated in writing to all participants in advance of the meeting.

ii. That the PCQO fully investigate and provide [the complainants] with a detailed response regarding their concerns about alleged "retaliation" by CMHA prior to the [date] meeting.

Summary of Response:

i. IH was always willing to hold a meeting with [Complainant A], and that a referral to CMHA has been offered. It also states that [Complainant B] indicated that they are not interested in returning to CMHA.

ii. IH states that the issue of alleged retaliation was already dealt with in the Human Rights Tribunal.

11. Complaint about the care, medication and monitoring at an acute care facility

Recommendation:

i. Notwithstanding the excellent quality of care provided to [the patient] and thorough response by [a PCQO staff member], the board recommends that [the PCQO staff member] provide an additional detailed response to the complainant to answer outstanding questions regarding

- The reason the equipment (IV) was removed.
- That the patient was being monitored by nurses prior to being arrested.
- If the patient's medication protocol was changed, and if so, the reasons.

Summary of Response:

i. The staff member worked with the patient's care providers to answer these questions, and a letter was sent to the complainant detailing the answers.

12. Complaint about rural transfer protocols and the PCQO response

Recommendation:

i. That IH ensure that, prior to investigating a complaint, the PCQO records and confirms the issues of the complaint with the complainant; and that these issues of compliant are recorded in the Patient Safety and Learning System (PSLS) Complaints Module.

ii. That IH have the PCQO provide the complainant with answers to the specific questions brought forward, specifically —

a. Why the patient was not transferred on the night of [date], to [acute care facility], with reference to the medical decisions and orders written; and

b. Why a review by the Medical Quality Committee did not proceed as recommended [date].

Summary of Response:

i. IH uses the Guidelines for Complaints Investigation, which state "ensure that the outcome of the investigation matches the expectations and objectives discussed with the complainant initially - support any differences with clear and logical explanations." The complaint file in question in the PSLS contains four references which indicated that the officer clarified the complainant's expectations.

ii. The PCQO will communicate with the complainant as requested and the board will be provided a copy of this correspondence.

13. Complaint about an unnecessarily painful colonoscopy due to lack of sedation

Recommendation:

i. That IH investigate the complaint further, including interviewing all medical and nursing staff in attendance at the time of the procedure, and provide the results of the investigation to the complainant ensuring all questions and concerns are addressed.

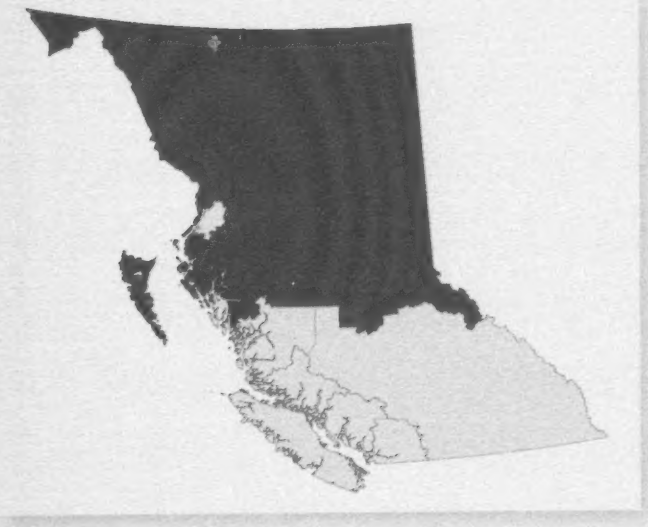
Summary of Response:

i. IH's review of the records, interview with the patient and the licensed practical nurse provided sufficient information to validate the concerns of the patient. Information received from the chief of staff in this situation should have been followed up more thoroughly and also directed the patient to the College of Physicians and Surgeons of British Columbia (CPSBC) as the board pointed out, "...matters pertaining to the clinical practice of physicians are best addressed by the CPSBC."

IH acknowledged that investigation and communication related to such reviews should be conducted in more detail in the future and ensure the patient understands the findings as outlined in the correspondence.

Additionally, IH recognized that more than one patient raised concerns related to gastroscopy/ colonoscopy and implemented processes to ensure improvement in a number of areas including:

- reinforcing the process for verification of consent for the procedure and be specifically communicated prior to the procedure.
- charting of the patient experience should be more thorough. Any adverse event will be documented in the PSLS system for appropriate follow up.
- a pain assessment tool will be used for the purpose of charting and informing the attending physician regarding the patient experience at the time of the procedure.
- nurses and physicians will be alerted to ensure that sufficient time is allowed for sedation to take effect.



Northern Health (NH) – Recommendations and Responses

- NH is responsible for serving over two-thirds of B.C.'s landscape, with about 300,000 people spread over a broad geographical area.
- The board reviewed three cases from NH in 2011/12, resulting in nine recommendations. Eight recommendations were for care quality improvement, while one was to improve the complaints process.
- Review requests received included concerns regarding care plans being updated and shared with the appropriate staff and family. In response, NH is supporting care staff in partnering with families, reviewing how care plans are shared, and considering initiatives to improve communication between care settings.

1. Complaint regarding the reason for and circumstances of a CT scan and subsequent death

Recommendation:

i. That NH arrange a care conference with the patient's family and the medical professionals involved in care to discuss any outstanding questions or concerns the family may have.

ii. That NH review the protocols in place for a patient in the CT scan room to notify personnel of an emergency.

iii. That NH ensure that the Patient Care Quality Office (PCQO) investigate and respond to the care quality complaints it receives, as required by the *Patient Care Quality Review Board Act.*

Summary of Response:

i. NH is prepared to organize a meeting with the complainant if the complainant wishes.

ii. NH reviewed CT practices with staff in the context of this incident, and described renovations to the CT room which place patients in constant view of technicians.

iii. PCQO is communicating with all NH sites to emphasize "response required for timely notification of the PCQO." They report that the Patient Safety Learning System includes directions re: involving the PCQO in patient complaints.

2. Complaint that a lack of quality care and neglect at [acute care facility] led to more health care concerns

Recommendation:

i. That NH review this case with regard to the clear identification of a care plan that was a shared decision plan with the family and provided direction to the multiple physicians and nurses involved in delivering care to the patient: In this case a care plan might have included —

- *a.* A fall assessment and a falls prevention strategy.
- *b.* A pain assessment and management plan in alignment with an appropriate pain management plan.
- *c.* A gerontological assessment.

ii. That NH ensure that staff involved in patient care be reminded to listen to the advice and information provided by family members of patients in their care as patient-centered medical care is based upon shared decision making.

iii. That NH ensure that the most responsible physician (MRP) be clearly identified to the patient, his or her family and to the staff. In the event that the primary MRP is not available, another replacement physician must be designated and identified as the MRP in their place.

iv. That staff understand and implement the NH delirium best practices when patients exhibit delirium.

v. That NH provide to the family and to the board what changes and follow-up measures will be taken as a result of this case.

Summary of Response:

i. NH explained their current practice for documenting care plans (a transient document that is not included in permanent charts) and indicated that their falls prevention strategy is available on their website (along with tools for assessing patients and decreasing their risks). They suggested that all patients have pain assessments and, since this case, there has been an increased focus on senior patients through daily discussion during rounds.

ii. Nurses involved in the case were reminded at a staff meeting about the need to involve patients and their families in care planning.

iii. NH re-iterated their current medical staff rules (that members away from practice indicate the names of those assuming responsibility) and advised that nurses are always aware of who the MRP is – but conceded that "this may not always be communicated to the patient or family in a timely manner." A reminder of the rules was put on the agenda of the next general medical staff meeting at the facility.

iv. NH re-iterated their current practice for orienting staff, and responded that the clinical nurse educator is planning to update all staff regarding the delirium best practices.

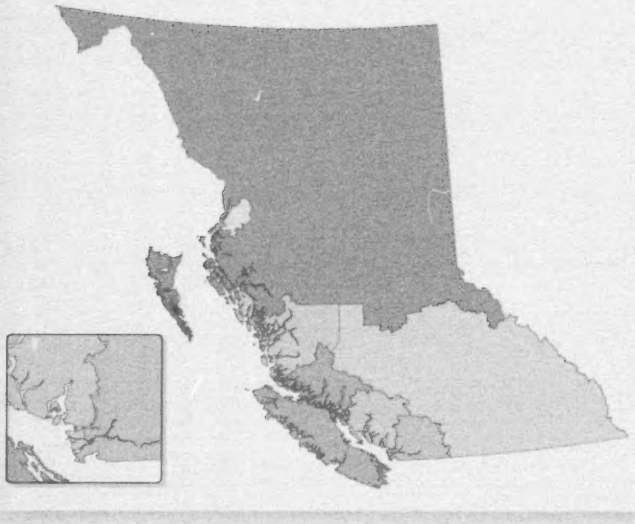
3. Complainant dissatisfied with the occupational therapy support and the medical equipment provided

Recommendation:

i. That NH review the current plan in place for the complainant and work with the complainant to ensure the care plan is up to date. With the complainant's concurrence, the care plan should include a mental health assessment to ensure that the direction for treatment and support is meeting the complainant's overall care needs.

Summary of Response:

i. NH indicates that staff have committed to reviewing the care plan with the complainant.



Provincial Health Services Authority (PHSA) – Recommendations and Responses

- PHSA is responsible for specific provincial agencies and services. There are 21 agencies and programs that fall under the purview of the PHSA. These include: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Mental Health and Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, Cardiac Services BC, Perinatal Services BC, BC Ambulance Service, BC Autism Assessment Network, Health Shared Services BC, PHSA Aboriginal Health Program, Provincial Blood Coordinating Office, Provincial Infection Control Network of BC, Provincial Surgical Services Program, Provincial Emergency Services Project, trauma, specialized diagnostics, specialized cancer surgery and Telehealth.
- The board reviewed three cases from PHSA this period, resulting in seven recommendations. Four recommendations were for care quality improvement and three were to improve the complaints process.
- The board received fewer review requests from those patients, clients and residents whom accessed these provincial services. The board made recommendations relating to childbirth policies, birth plan development and patient communication.

1. Complaint regarding a lack of follow-up care after surgery

Recommendation:

i. That PHSA provide a more substantive response to the complainant's outstanding questions.

Summary of Response:

i. The PHSA response to the complainant includes more comprehensive answers to the questions raised by the complaint.

2. Concerns about care at acute care facility

Recommendation:

i. That PHSA work with the facility's administration to update the Refusal of Treatment form and guidelines to ensure that they are in line with the *Public Health Act* and section 17 of the Health Act Communicable Disease Regulation.

ii. That PHSA work with the facility to update the placenta disposition/pathology policy to ensure that the process, roles and responsibilities are clear for atypical births. The communication of the parents' request for the placenta should also be documented throughout the chain of custody of the placenta, from the operating room to the pathology lab and then back to the parents.

iii. That PHSA work with [acute care facility] to ensure that a birth plan document with the mother's specific requests is included in the mother's chart during her admission and that no exception to that be made in instances where a birth plan exists for a birth planned for outside the hospital but circumstances lead to admission to hospital for the delivery and birth.

iv. That PHSA's Patient Care Quality Office (PCQO) follow-up with the complainant after responding to the recommendations of the board to ensure that all outstanding questions have been addressed.

Summary of Response:

i. PHSA had recently implemented a new informed consent policy along with site-wide, multidisciplinary education sessions that included discussion about informed refusal. [Acute care facility] had also recently developed an Informed Consent Working Group that is developing a standard consent form.

ii. As a result of this case, the facility revised their disposition of placenta policy to include the process for placentas sent to pathology.

iii. PHSA has a brochure available for women that includes a template for them to record their birth plan. PHSA discussed the recommendation at their midwifery department meeting and determined that midwives ask their patients to bring a copy of their birth plans with them to the hospital for inclusion in their chart. In the future, midwives will also discuss this with women planning a home birth, so that in the event they are transferred to a hospital for care they have a copy of their birth plan to share with providers. PHSA noted that midwives reported many of their clients opt to not use a birth plan.

iv. PHSA will follow up with the complainant regarding their questions.

3. Access to cancer diagnosis and subsequent treatment

Recommendation:

i. That PHSA have the BC Cancer Agency clarify on its website:

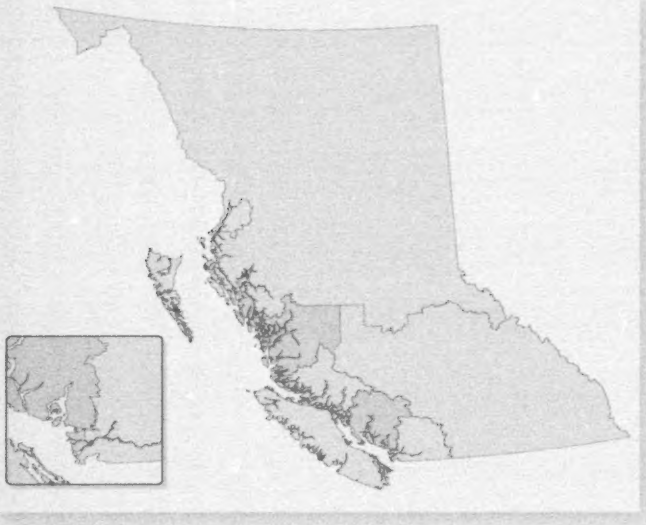
- Its role in regard to the diagnosis of cancer.
- That it only accepts patients who have been diagnosed with cancer and are referred by a physician.

ii. That PHSA have the PCQO review their process to ensure care quality complaints as defined by the *Patient Care Quality Review Board Act* are responded to appropriately including advice to complainants of their right to have complaints reviewed by the board regardless of whether the complainant has been formally admitted or accepted as a patient.

Summary of Response:

i. BC Cancer Agency is reviewing all current web content and determining appropriate changes to ensure it is clear how to access specialized services for both patients and referring physicians.

ii. PHSA will have the PCQO review their process to ensure care quality complaints are responded to appropriately, including advising the complainant of their right to have complaints reviewed by the board.



Vancouver Coastal Health (VCH) – Recommendations and Responses

- VCH is responsible for serving two densely populated regions with more than 1.1 million people.
- The board reviewed 17 cases from VCH in 2011/12, resulting in 22 recommendations. 20 recommendations were for care quality improvement, while two were to improve the complaints process.
- The recommendations to VCH covered a broad range of issues including communication between care providers and family. In response VCH is supporting care staff in keeping families up to date, and providing training to staff to recognize potential conflict and employ a variety of means to address it, including identifying when additional support is needed.

1. Complaint regarding a fall during post-operative recovery

Recommendation:

i. That VCH review [acute care facility's] total hip replacement guidelines and consider adopting the revised three pathways policy under development at St. Paul's Hospital.

ii. That VCH ensure that [acute care facility] orthopaedic staff is aware of the health authority's protocols and expectations for patient assessments.

iii. That the VCH's Patient Care Quality Office (PCQO) inform the complainant about all of the initiatives undertaken in response to this adverse event.

Summary of Response:

i. Senior leaders at [acute care facility] are reviewing the pathways from St. Paul's Hospital to consider adoption or integration with current protocols.

ii. Since this event, a clinical nurse educator has been hired for the ward. Part of this person's responsibilities will be to facilitate safety huddles with all staff working with orthopaedic patients, and ensure adherence to protocols and documentation standards.

iii. The complainant was informed of the above initiatives in the PCQO's official closing response.

2. Complaint regarding lack of communication about the transportation fee policy

Recommendation:

i. That VCH review and update their "When Someone Dies..." family brochure to indicate the responsibility for costs associated with a transfer of a deceased family member within the province.

Summary of Response:

i. The VCH PCQO has reviewed the brochure and has made the recommended update. The wording has been updated and will be reflected in the next printed edition of the family brochure.

3. Complaint regarding care provided in hospital, lack of communication from care team, and disagreement over the care plan

Recommendation:

i. That, whenever practicable, the patient and the family should be informed and provided with an explanation as to where and why a patient is being transferred to another unit prior to the transfer occurring.

ii. That, in addition to the staff training provided on professional and respectful communication expectations program, the program used should incorporate information and training on how to best achieve informed, shared decision-making practices.

iii. That VCH consider using mediation services when cases of conflict about treatment arise among the care staff, the patient and the patient's family, and that staff should be trained to recognize contentious situations and how best to de-escalate them, while ensuring quality of care.

Summary of Response:

i. VCH agrees that keeping families up to date is key to optimizing satisfaction. This expectation will be reinforced through a presentation at a patient services managers' forum, and circulated throughout VCH via an article in an internal communication newsletter.

ii. VCH and Providence Health Care will reinforce this topic in a planned education strategy concerning changes in various statutes regarding consent and substitute decision making.

iii. VCH is confident that it is the practice of teams throughout the health authority to recognize potential conflict and employ a variety of means to address it, including identifying when additional support is needed. VCH client relations will include learning from this case in education sessions about a new guideline regarding how to deal with challenging situations involving patients and family.

4. Complaint regarding care in palliative care unit, medication charting issues, and communication between care providers and family

Recommendation:

i. That VCH review its policy related to physician responsibility for patient care (palliative care on call physician and general practitioner) in their palliative care facility, so that the policy can be clearly explained to patients along with their rights concerning choice of physician and their course of treatment.

Summary of Response:

i. The palliative care on call physician group at [acute care facility] will adopt standard procedures to clarify their role to patients, and a brochure will be developed for palliative in-patients and their families that clarifies the policy and patient rights re choice of physician.

5. Complaint regarding timing and circumstances of discharge from a rehabilitation centre, the care provided by care team and the rehabilitation tools received

Recommendation:

i. That VCH review the events of [dates] a view to determining whether the complainant may benefit from further equipment assessment by staff [rehabilitation centre].

Summary of Response:

i. In response to this recommendation [rehabilitation centre] staff reviewed and assessed the care provided at [rehabilitation centre]. [The staff members] do not believe [the complainant] requires a readmission to [rehabilitation centre] for further equipment assessment. They will provide equipment related consultation services to the clinicians involved in [the complainant's] care.

6. Complainant alleged that [the patient] had a pressure sore that went undiagnosed and untreated

Recommendation:

i. The board recommends that VCH provide training to the staff in the [acute care facility] Transitional Care Unit on the assessment and prevention of skin breakdown as well as mandatory education on the requirements for detailed patient charting.

ii. The boards recommend that following the training, VCH conduct audits of the Transitional Care Unit charting to ensure that all staff are applying the skin care training and education that they received.

iii. The board recommends that VCH review and amend the Patient Care Flowsheet in use at [acute care facility], to include additional detail in the skin and wound section. Specifically the flowsheet should indicate that the care aide's observations of skin condition have been reported to a registered nurse, and were charted by a registered nurse. The columns in the flowsheet should be amended to include the time of day and initials.

Summary of Response:

i. The manager of the Transitional Care Unit has completed the recommended training and the opportunity for clarity in process and quality improvement generally has been discussed with residential care managers across VCH.

ii. Sustainment of the practice improvement will form part of the day to day supervision of the staff in the Transitional Care Unit.

iii. Sustainment of the practice improvement will form part of the day to day supervision of the staff in the Transitional Care Unit.

7. Complaint regarding the denial of access to mental health services

Recommendation:

i. That VCH arrange for [mental health centre] to reassess the complainant for services.

- If the complainant cooperates and attends an interview with an alternate psychiatrist, then the results of that interview should be used in the reassessment.
- If he does not, then the reassessment should be done based upon the records available.
- The reassessment should include a detailed transition plan, if transition to another mental health team remains the recommended course of action.

Summary of Response:

i. The care team is contacting [the complainant] to verify that their health status is unchanged, and if so they will offer to provide care to assist in the transition to [the complainant's] new home health authority.

8. Complaint regarding inappropriate denial of mental health services

Recommendation:

i. That VCH bring its informal policy related to [acute care facility] outpatient psychiatry services in line with the messaging on its website, and ensure that it corresponds with the Canadian Medical Association's ethical standards.

ii. That VCH organize an interdisciplinary team evaluation of the complainant's care needs, and also consider the possibility of referring the complainant to another psychiatrist within [acute care facility] outpatient psychiatry department. The intent of the interdisciplinary team is to include the health care professionals reasonably involved in the complainant's care, which may include psychiatrists, the complainant's family physician, a mental health nurse, a social worker and a clinical psychologist.

iii. That VCH have [acute care facility] resend the outpatient psychiatry department discharge summary to the patient's family physician and request that the family physician confirm receipt of the summary in writing. Alternatively, [acute care facility] could provide the patient with a copy of the discharge summary, and the patient could then provide the summary to their family physician.

Summary of Response:

i. VCH is undertaking revision and redesign of their website. They have removed the information concerning outpatient services, and will update the site to clarify the scope of services offered.

ii. After bringing forward the recommendation, the Patient Care Quality Office (PCQO) was advised that such a review had already occurred. This type of review is not normally recorded in patient charts. The PCQO expressed regret that the board did not have this information for its review of the case.

The response notes that the patient has been referred to three psychiatrists and one psychologist within the program, and has trialed different types of medication. The patient made the decision to stop seeing [psychiatrist] and also declined to see a psychiatrist in the community.

iii. The summary has been re-sent to the physician, and receipt has been confirmed by the physician's office.

9. Complaint regarding an involuntary admission and lack of privacy for mother of a newborn

Recommendation:

i. The board recommends to VCH that if intimate security guard supervision of a woman is required it should be performed by a female security guard and if a male security guard is used, the reason should be documented in the chart. This should be included in training protocols for hospital staff and security guard service providers. Additionally, if possible, a provision should be included in the contract with its security contractor to require this in the future.

Summary of Response:

i. While VCH agrees that patient requests for security guards of the same gender should be considered, they note that accommodating those requests may not always be possible. However, VCH expects all members of their security service to be professional in their interaction with patients and officers are trained in 'intimate' supervision of other genders. They believe the current arrangements for sensitivity are satisfactorily addressed.

VCH found variations in their charting practice and will implement that aspect of the board's recommendation by [date]. However, they explain that shift-by-shift documentation of the patient's requests may not be feasible when supervision spans a number of shifts.

10. Complaint about reduction of home care services

Recommendation:

i. That VCH ensure that assessments for determining home support needs take into account all medical professional opinions and clinical judgement when appropriate.

ii. That VCH have [the complainant] reassessed for home support needs with appropriate regard being paid to the existing physician's report concerning [the complainant's] condition unless the person conducting the assessment is of the view that the physician's report on file needs to be updated, in which case a current physician consultation should be obtained and given due weight in the home support assessment.

Summary of Response:

i. VCH is in agreement of the need to for a thorough clinical assessment of client needs. This assessment must take into account all health and functionality of the client including medical assessment and the opinion of medical professionals.

The board's recommendations have been shared with [the complainant's] care team, and the manager has reminded all case managers to ensure that the opinion of the medical professionals it taken into consideration in the assessments.

ii. VCH is in agreement of the need for an updated assessment on [the complainant] and their needs; [the complainant's] case manager visited on [date] to begin the assessment. [The complainant's] physician was contacted on [date] to request updated information on [the complainant's] situation and abilities, and this information will be considered in the determination of home support needs. The team will also consider the VCH Regional Home Support Service Guidelines, 2008, that outlines:

"Home Support is not intended to be utilized as a house cleaning service. Clients will be directed to choose alternative avenues for maintaining their home (family, friends, and private pay) for all levels of care."

11. Complaint regarding a fall in a residential care facility and subsequent disagreement over care of the resident

Recommendation:

i. That VCH ensures [residential care facility]staff is aware of the most relevant and up-to-date falls information and training materials that are available on both the VCH and the Ministry of Health websites.

ii. That VCH remind [residential care facility] staff to ensure that the resident's primary contact person is immediately and proactively contacted following an incident that could compromise the resident's health.

iii. That VCH consider using mediation services when cases of conflict about treatment arise among the care staff, the resident and the resident's family, and that staff should be trained to recognise contentious situations and how best to de-escalate them, while ensuring quality patient care.

Summary of Response:

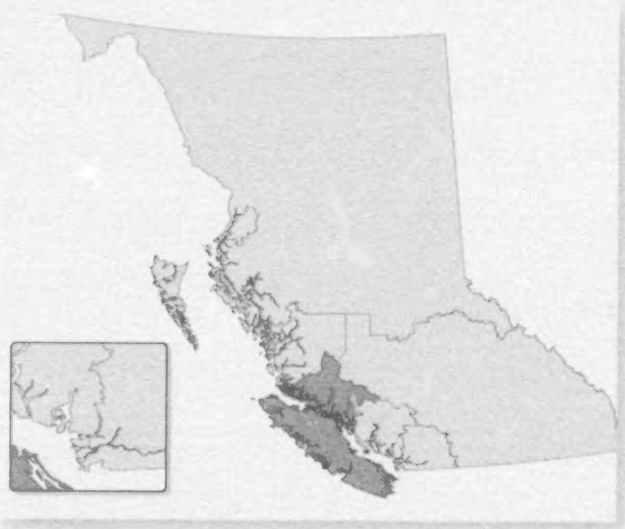
i. [Residential care facility] has committed to reviewing the updated guidelines and determine the necessary education/training for staff.

ii. VCH issued a bulletin to all sites reminding them that primary contact persons should be immediately and proactively contacted following an incident that could compromise a resident's health.

iii. VCH residential care leadership values the support mediation services can provide and will ensure they are made available. They will remind all case managers for contracted residential care sites of this availability.

Vancouver Island Health Authority (VIHA) – Recommendations and Responses

- VIHA is responsible for more than 760,000 people spread over the Islands and the Mainland.
- The board reviewed 21 cases from VIHA in 2011/12, resulting in 24 recommendations. Of those recommendations, 20 were for care quality improvement, while four were to improve the complaints process.
- Many of the board's recommendations to VIHA focused on communication. Recommendations included, discharge communication for patients, and that the health authority ensures that patients who are non-residents of Canada, be required to sign or initial the Visitors Rate Sheet, and patients should be provided with a copy of all signed documents.
- VIHA took action by ensuring that all documents provided to families during the intake meeting clearly outline goals and expectations upon discharge and are in writing and signed by the parties. In response to the recommendation that patients who are non-residents of Canada sign or initial the Visitors Rate Sheet, VIHA responded that a project is underway to review and improve their policies and procedures surrounding the methods and means of communicating financial responsibility to non resident charge patients, including potential language barriers.



1. Complaint regarding access to bathing services

Recommendation:

i. That VIHA explore all available options to provide a regular bathing program to the patient, and that in their quest all parties recognize that the locations and schedules may not meet their optimum outcome.

Summary of Response:

i. For the submerged bathing that [the complainant] requests, a community bathing program must have the appropriate surfaces, equipment and staffing to manage the level of care and maintain the workers' safety. [Long term care facility] is the most appropriate facility to meet [the complainant's] needs, and at the earliest opportunity, he will be assessed and considered for the next available spot. VIHA staff will remain engaged with the family to explore this opportunity.

2. Complaint about care and treatment at residential care facility

Recommendation:

i. That VIHA inform [residential care facility] of the requirement under section 3 of the Residents' Bill of Rights for residents to have access to a fair and effective process to express concerns, make complaints or resolve disputes within the facility; to be informed as to how to make a complaint to an authority outside the facility; and, to have his or her family or representative exercise the rights under this clause on his or her behalf.

ii. That VIHA require that [residential care facility] provide a written apology to [the complainant] acknowledging the breakdown in communication and that [residential care facility] set up a meeting with [the complainant] to discuss how they will move forward in the future to address concerns brought to their attention by residents or family members.

iii. That VIHA ensure that [residential care facility] provides [the complainant] with a copy of the health and safety plan developed for [the resident].

Summary of Response:

i. VIHA has officially informed [residential care facility] of the requirements under Section 3 of the Resident's Bill of Rights.

ii. [Residential care facility] is arranging a meeting between [the complainant], the board chair and executive director. Meeting arranged as soon as possible based on [the complainant's] availability. [Residential care facility] will provide [the complainant] with a written apology. [Residential care facility's] informal complaints process has been updated to reflect complaints that can be made to the Patient Care Quality Office and licensing. The process will be presented to the Resident and Family Council by [date].

iii. [Residential care facility] will provide [the complainant] with a copy of the original Health and Safety Plan at the in-person meeting.

3. Complaint that patient not told about drill bits left in leg after surgery

Recommendation:

i. The board recommends that VIHA ensure that all hospitals within the health authority are following the same standard for reporting adverse events.

Summary of Response:

i. Concrete improvements have been made to ensure that all hospitals within VIHA follow the same standard for reporting adverse events. The new online Patient Safety and Learning System (PSLS) standardizes processes. As well, ongoing staff training ensures that all facets of adverse events are captured. The PSLS system also ensures that issues are resolved in a timely manner and that any trends in adverse events are identified and addressed.

In addition, a province-wide A request for proposal has been issued for an instrument tracking system and VIHA's three main acute sites will be using this system. It will allow the tracking of instruments to a patient, will capture instruments used per case, and sterilization times and parameters

4. Complaint about the discharge process from a youth mental health facility

Recommendation:

i. That VIHA ensures that during the intake meeting with the family, expectations are clearly outlined, that the expectations be outlined in writing, and that they are signed by the parties.

Summary of Response:

i. VIHA is creating a new acceptance letter that will outline initial expectations of what parents can expect from a voluntary admission and they will be asked to sign off their agreement prior to admission on the letter and return in a serious adverse event.

VIHA stated that all contacts and materials provided to families prior to admission, through intake, are now documented. Random audits are occurring to ensure compliance. Every family will receive a folder prior to admission containing: Simple Steps for a Safe Hospital Stay brochure, Child Youth and Family Mental Health Service Safety Information brochure, brochure for the Representative for Child and Youth, the F.O.R.C.E. Society for Kids' Mental Health (Families Organized for Recognition and Care Equality) contact, Kelty Resource Centre contact, a local map, a local parenting magazine, a contact for the Patient Care Quality Office, a parking pass, a unit specific welcome booklet, a welcome letter and a newly developed, parent approved Q&A fact sheet about the admission and expectations.

5. Complaint regarding inadequate care and lack of patient supervision in an acute care facility

Recommendation:

i. That the hospital review this case at grand rounds with all medical students, residents, and those involved in teaching and training.

ii. That VIHA remind staff of the signs and symptoms of delirium and review the current protocol with staff.

iii. That VIHA ensure that each patient be assigned a most responsible physician (MRP) upon a transfer between units in accordance with the MRP policy 12.1.1 and that the MRP be kept updated on the patient's current medical condition.

iv. That protection services be called immediately when nursing staff are alerted by an alarm and unable to attend the scene

Summary of Response:

i. As VIHA does not have a grand rounds, the case will be reviewed in department quality improvement rounds. VIHA has requested that this case review be incorporated into training of medical students and residents at UBC Faculty of Medicine.

ii. Delirium protocols are in place, and quality councils and program directors have been told to ensure staff is reminded of this protocol.

iii. An MRP policy is in place and processes of describing transfer of care are outlined in the VIHA Medical Staff Rules. A memo has gone out to all VIHA Medical Advisory Committee chairs to reinforce the importance of the policy. Communication to all clinical programs to reinforce notification to MRP on patient condition changes has taken place.

iv. All clinical directors have been advised to provide this direction to their staff.

6. Complaint about care and discharge process for a mental health patient

Recommendation:

i. That the VIHA Patient Care Quality Office (PCQO) provides a fulsome response to complainants that details all the information from the PCQO's investigation.

Summary of Response:

i. While the mental health and addiction services team shared the findings with the family directly, the PCQO will provide an additional closing letter to the family.

7. Complaint about billing and communication from an acute care facility for a non-resident of Canada

Recommendation:

i. The board recommends that VIHA ensure that patients, who are non-residents of Canada, be required to sign or initial the Visitors Rate Sheet, and patients should be provided with a copy of all signed documents.

ii. The board recommends that VIHA make the Non-Resident of Canada Agreement and Visitor Rate Sheet available in languages applicable to their health authority.

iii. The board recommends that VIHA review the non-resident of Canada in-patient script to ensure patients are advised that their bill will be based on the cost of the treatments received and that the Visitor Rate Sheet represents a list of the various items that may be included in the bill.

Summary of Response:

i. Currently, VIHA has a project underway to review and improve their policies and procedures surrounding the methods and means of communicating financial responsibility to non resident charge (NRC) patients. This involves revising the documentation to ensure that there is a section on the NRC form to be initialled by the patient or FRA (financially responsible agent) which acknowledges that the patient has been informed and understands the Visitors' Rates. Completion Date – March 31, 2012

ii. On a go forward basis, VIHA will be reviewing out-of-country patient files to identify whether or not particular language groups are represented in a large enough volume to support preparing documents in a particular language. In the interim, to ensure that non-English speaking visitors are fully cognizant of their financial responsibility, VIHA will make every effort to have available a suitable interpreter to explain relevant documentation. The documentation will have a section to be initialled by the patient acknowledging that they have received translation services, and that they understand their financial obligations.

iii. A project is currently underway to review and revise the non-resident of Canada in-patient script to ensure that patients are advised that their bill will be based on the cost of the treatments received, and that the Visitor Rate Sheet represents a list of the various items that may be included in the bill.

8. Complaint regarding the cancellation of eye surgery

Recommendation:

i. The board recommends VIHA send a new letter to the complainant outlining the accurate reason why the eye surgery was cancelled and include an apology for the confusion regarding why the eye-surgery was cancelled.

Summary of Response:

i. The PCQO has confirmed with the program area the reason the patient's eye surgery was postponed. VIHA was not privy to discussions between the physician and patient regarding the reasons provided for the cancellation. VIHA will send an additional letter clarifying why the PCQO and the surgeon provided differing information.

9. Complaint that protocol errors were made in Emergency Department

Recommendation:

i. That VIHA have the facility initiate a review with emergency department medical staff regarding improved medical charting, appropriate admission and discharge protocols, and the appropriate practice for ordering tests.

ii. That VIHA ensure patients are provided with clear follow-up instructions upon discharge from hospital, and that patients acknowledge they understand the instructions.

Summary of Response:

i. The development of the electronic health record is in process and is expected to improve legibility and standardization of care, including admission and discharge protocols. Trial of the charting system to commence September 2012 in Nanaimo and move to [acute care facility] after refinement.

Medical charting improvements will be addressed with the implementation of the electronic health record (EHR). Enhanced patient information and follow-up information for patients has been included in the EHR review work on admission and discharge process. Report back February 2012.

The importance of the discharge plan documentation and providing instructions to the patient, including follow-up arrangements, will be reviewed and reiterated at the [acute care facility] emergency department (ED) meeting.

ii. Discharge flow plans, follow-up plans and discharge instructions will be included in the EHR. The review of workflow processes regarding discharge instructions is a major component of VIHA's ED lean design project, which is currently in progress. In the interim, follow-up will be done with managers and the site medical chief at the ED Quality Council. Staff will also be reminded to ensure patients are provided with and understand clear follow-up instructions upon discharge from hospital. Follow-up will be done within the ED Quality Council process.

10. Complaint about quality of care and communication by acute care facility staff

Recommendation:

i. That VIHA have the PCQO provide the family with the specific details about the care and monitoring [the patient] received by nursing staff on [date].

ii. That VIHA review the progress of the PCQO in completing its internal recommendations arising from the root cause analysis done in response to this matter and provide an update on this to the complainant and the board.

Summary of Response:

i. A follow up letter was sent to the complainant offering further information on nursing documentation, including how a key organizational initiative - care delivery model redesign - is supporting improved documentation and expectations for rounds. This initiative focuses on the purpose and components of the hourly care rounds. A checklist to ensure compliance has beenadded to the nursing flow sheet.

ii. VIHA provided an update to the complainant and the board on actions being taken.

11. Complaint about lost laboratory specimen

Recommendation:

i. That VIHA have the PCQO call the complainant and schedule a meeting to go through each concern with the operating room surgeon, the PCQO, and the nurse and laboratory representative involved in the surgery.

ii. That VIHA proceed with the audits of compliance for the Surgical Safety Checklist that is to be reported to the VIHA Surgery Quality Council report to the Ministry of Health regarding compliance as they request it.

iii. That VIHA considers implementing an electronic or computerized tracking system for tracking specimens from the operating room to the laboratory.

Summary of Response:

i. Upon consultation and agreement with the patient, the PCQO has initiated the process to support a facilitated conversation with key individuals from the surgical program to have additional questions answered. The PCQO has spoken with [the complainant] on three occasions regarding this recommendation to ensure that this is an acceptable approach to this recommendation and is confident that this will assist in the resolution process.

ii. The surgical program will proceed with efforts to implement and audit the surgical safety checklist.

iii. VIHA considered this recommendation as written by the board. However, due to the operational and financial implications involved, implementation is not feasible at this time.

12. Complaint regarding discharge from Emergency Department without physician's consent

Recommendation:

i. That VIHA have this case reviewed in the emergency department quality improvement rounds. Particular emphasis should be placed on patient presentation and caregiver assessment of acute physical symptoms in patients with chronic mental health diagnosis.

ii. That VIHA institute an audit process for the revised January 2010 pre-discharge review protocol and report to the Ministry of Health regarding compliance as they request it.

Summary of Response:

i. VIHA will be conducting a review of the protocol used in diagnosing the patient's symptoms at the Emergency Department Regional Quality Council to be held this June.

ii. VIHA determined that a thorough review process would be more beneficial than an audit. At the June 2012 Regional Quality Council, the emergency department will review their current discharge pamphlet to ensure it reflects best practice in pre-discharge review protocol. Any required changes will be made. This will also ensure a regional approach to the issue.

Appendix A | *PCQO Volumes*

Appendix A details the volume of all complaints and inquiries received by the health authority Patient Care Quality Offices (PCQOs) in 2011/12, and compares the top five issues, or subjects of complaint, within the province and each health authority for 2009/10, 2010/11 and 2011/12.[3]

British Columbia

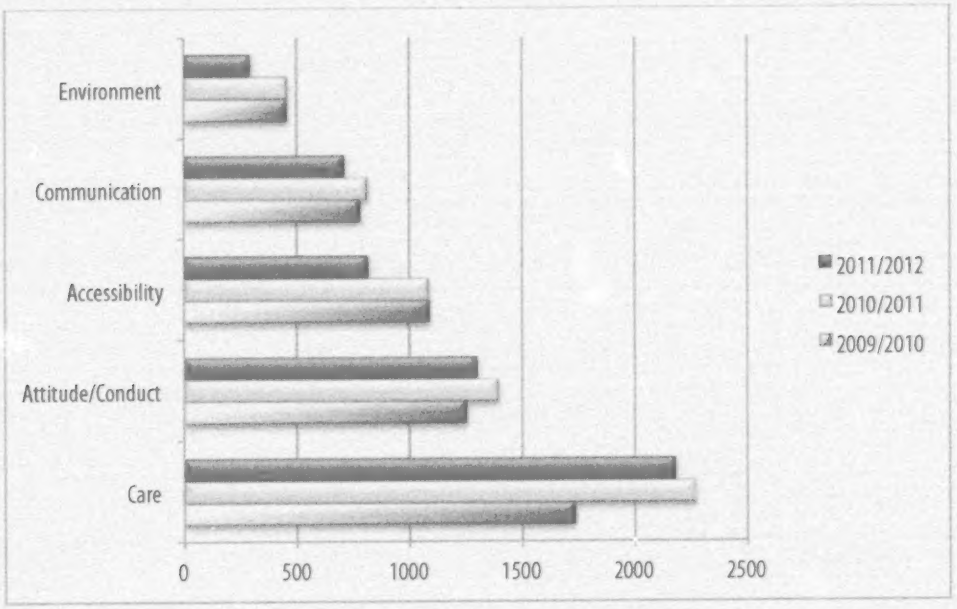
Table 3: PCQO Volume, B.C., 20011/12

BC	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	52	60	43	37	192
Care Quality Complaints	1,254	1,284	1,196	1,349	5,083
Inquiries	729	709	775	1,090	3,303
Total Volume	**2,035**	**2,053**	**2,014**	**2,476**	**8,578**

By definition, most care quality concerns relate to care – for example, deficiencies in care, misdiagnosis, or medication-related concerns – therefore, complaints tend to be concentrated in that category. In B.C., PCQOs logged 2,179 complaints related to care, which represents a decrease of 89 over 2010/11. Attitude and conduct followed with 1,303 complaints, with a decrease of 90 over 10/11. Accessibility (which includes issues such as wait-times for surgery or test results and the availability of services) was the third most frequently reported issue at 821. Communication was fourth at 715, followed by environment (which includes issues such as food services, housekeeping, and parking) at 299.

3 The Patient Care Quality Offices categorize patient complaints using a common reporting framework. Complaints are first categorized according to health sector – including Acute Care, Ambulatory Care, Emergency Care, Home and Community Care, Mental Health and Addictions, Residential Care, and Public Health, among others – then further broken down by subject. Last year we reported the top ten issues by sector and subject; this year we have reported the top five subjects ***across*** sectors, which gives a more accurate picture of the key concerns patients bring to their Patient Care Quality Offices. Note that one complaint typically encompasses more than one care issue, so the total number of care issues will generally be higher than the total number of complaints.

Chart 3: PCQO Top 5 Issues, B.C., 2009/10-2011/12



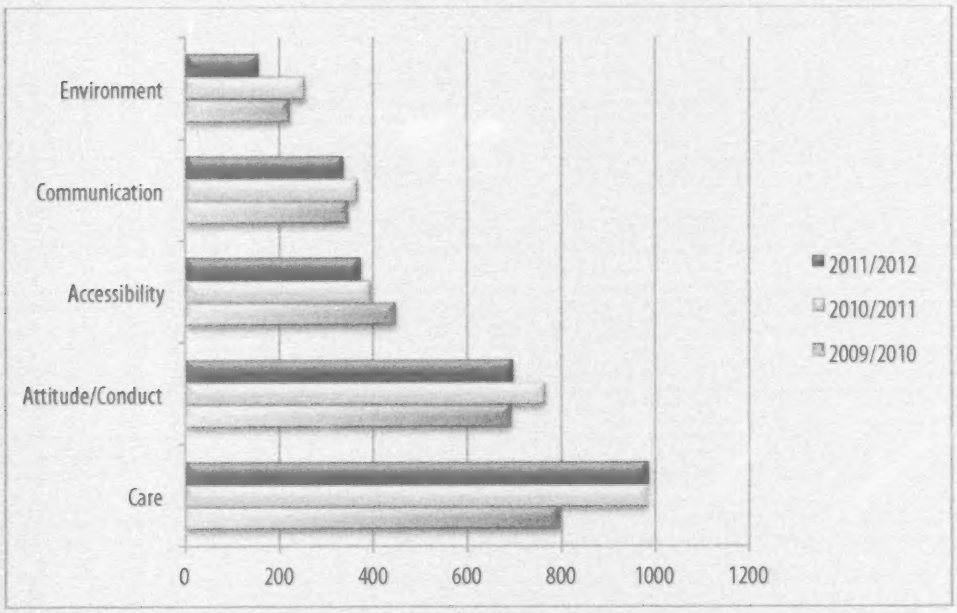
Fraser Health (FH)

Table 4: PCQO Volume, FH, 20011/12

FH	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	3	4	3	3	13
Care Quality Complaints	487	476	373	376	1,712
Inquiries	82	64	76	83	305
Total Volume	**572**	**544**	**452**	**462**	**2,030**

FH logged 983 complaints in the care category, which represents an increase of one over 2010/11. Attitude and conduct was the second most frequently reported concern with 697 complaints, 68 less than 2010/11. Accessibility was third at 373, followed by communication at 336 and environment at 156. Four out of the five categories saw a reduction in complaints from 11/12, with the exception of care which increased by one. Note that FH's service population is larger than other health authorities, while their geographic area is smaller – which results in a higher overall volume.

Chart 4: PCQO Top 5 Issues, FH, 2009/10-2011/12



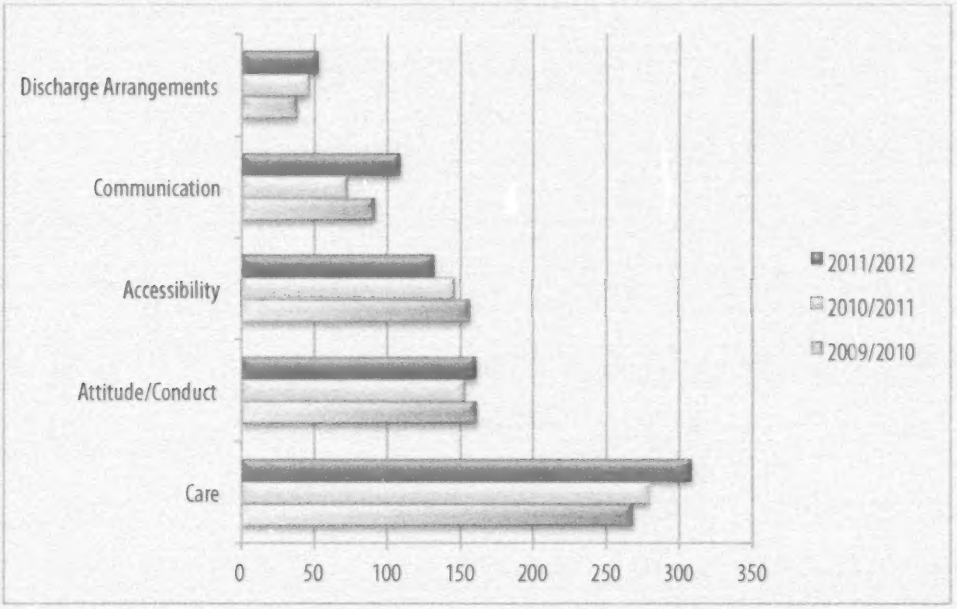
Interior Health (IH)

Table 5: PCQO Volume, IH, 20011/12

IH	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	15	13	12	7	47
Care Quality Complaints	228	227	236	288	979
Inquiries	68	77	110	113	368
Total Volume	**311**	**317**	**358**	**408**	**1,394**

IH logged 308 complaints in the care category, which represents an increase of 29 over last year. Attitude and conduct was the second most frequently reported concern with 161 complaints. Accessibility was third at 132, followed by communication at 109 and discharge arrangements (which includes issues such as incomplete discharge information, premature or delayed discharge, etc.) was fifth with 53 complaints.

Chart 5: PCQO Top 5 Issues, IH, 2009/10-2011/12



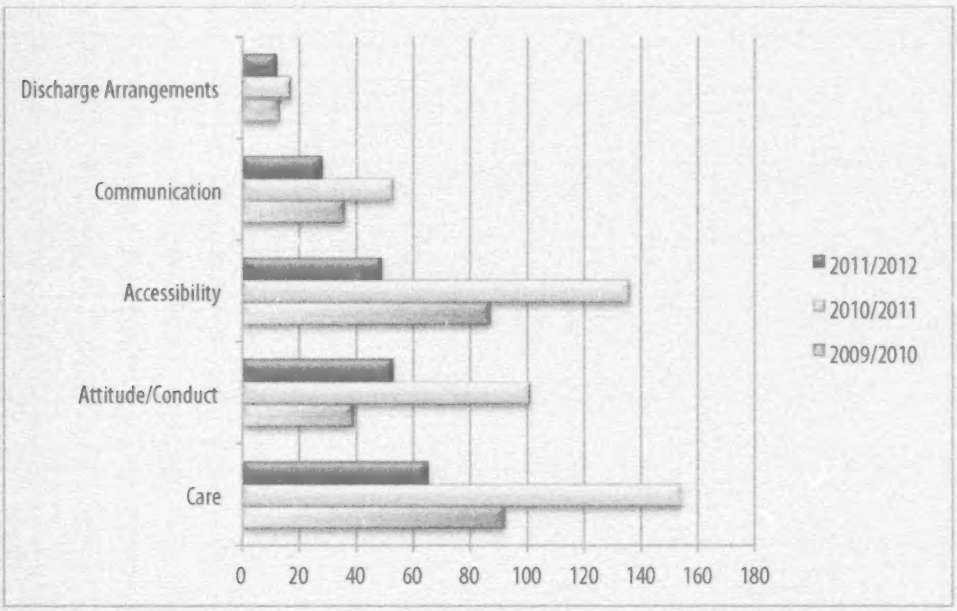
Northern Health (NH)

Table 6: PCQO Volume, NH, 2010/11

NH	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	4	11	4	7	26
Care Quality Complaints	58	38	34	28	158
Inquiries	26	31	12	10	79
Total Volume	**88**	**80**	**50**	**45**	**263**

NH logged 65 complaints in their care category, which represents a decrease of 89 over 2010/11. Attitude and conduct was the second most frequently reported concern at 53, followed by accessibility at 49. Communication was fourth at 28, followed closely by discharge arrangements at 12. While the geographic area is large, NH serves a smaller population relative to the other health authorities. As such, the smaller population may explain the lower volumes of care quality complaints.

Chart 6: PCQO Top 5 Issues, NH, 2010/11



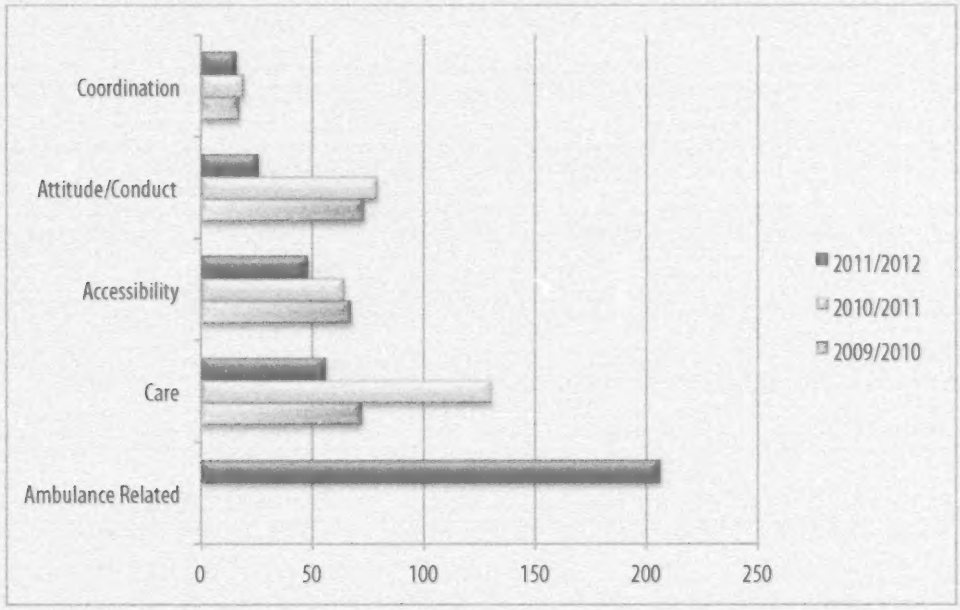
Provincial Health Services Authority (PHSA)

Table 7: PCQO Volume, PHSA, 2010/11

PHSA	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	1	0	3	1	5
Care Quality Complaints	88	67	93	101	349
Inquiries	221	182	278	645	1,326
Total Volume	**310**	**249**	**374**	**747**	**1,680**

Since PHSA began tracking BC Ambulance Service complaints in 2011/12, it has logged 206 complaints about Ambulance Related service. PHSA recorded care as the second most frequently reported care quality complaint at 56, a decrease of 74 from 2010/11, followed closely by accessibility at 48. Attitude and conduct was fourth with 26 complaints, followed by coordination with 16.

Chart 7: PCQO Top 5 Issues, PHSA, 2010/11



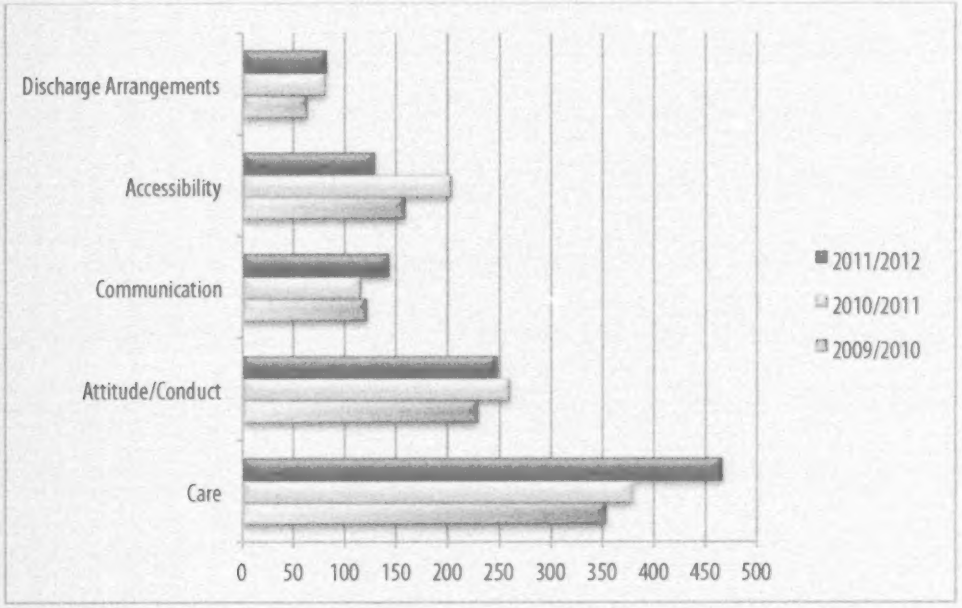
Vancouver Coastal Health (VCH)

Table 8: PCQO Volume, VCH, 2011/12

VCH	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	6	7	7	14	34
Care Quality Complaints	235	321	262	332	1,150
Inquiries	89	143	164	111	507
Total Volume	**330**	**471**	**433**	**457**	**1,691**

VCH logged 466 complaints in the care category, an increase of 87 over 2010/11. Attitude and conduct followed at 248, with communication at 143, accessibility at 129 and discharge arrangements at 82.

Chart 8: PCQO Top 5 Issues, VCH, 2009/10-2011/12



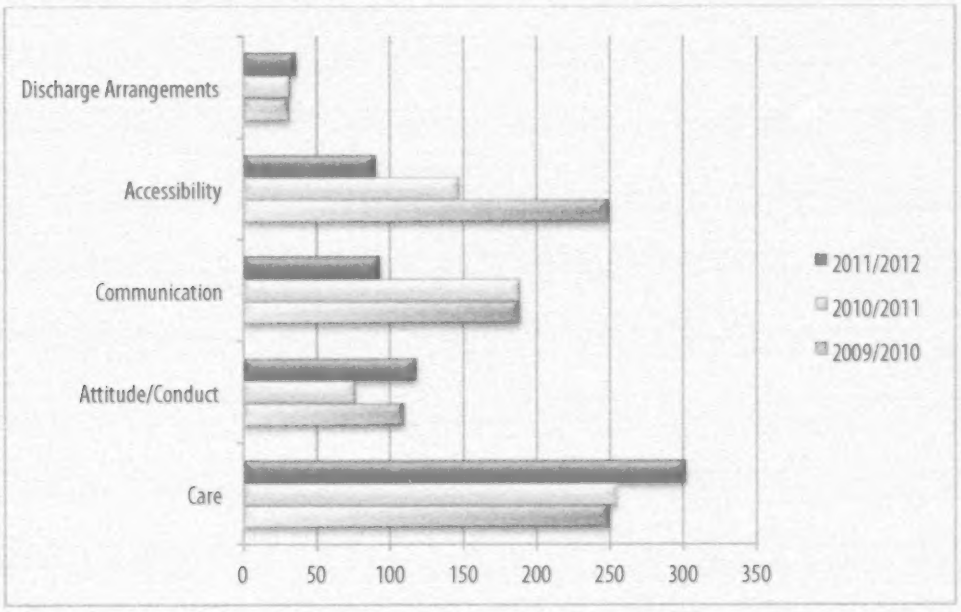
Vancouver Island Health Authority (VIHA)

Table 9: PCQO Volume, VIHA, 2011/12

VIHA	Apr-June 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Total
External Complaints	23	25	14	5	67
Care Quality Complaints	158	155	198	224	735
Inquiries	243	212	135	128	718
Total Volume	**424**	**392**	**347**	**357**	**1,520**

VIHA logged 301 concerns in the care category, an increase of 47 from 2010/11. Attitude and conduct was their second most frequently reported complaint at 118. Communication was third at 93, followed closely by accessibility at 90. Finally, VIHA logged 36 complaints about discharge arrangements in 2011/12.

Chart 9: PCQO Top 5 Issues, VIHA, 2009/10-2011/12



Appendix B | *Financial Information*

Expenditures		Actual 2010/11 $
Board Members		
Board Member meeting fees and expenses		116,552.79
	Total	*116,552.79*
Board Support		
Board Support Personnel		672,484.84
Board Support Travel		24,933.22
Legal Expenses and Professional Services		10,244
Office Business and Info Systems		32,613.23
	Total	*740,275.29*
Total Expenditures		**$856,828.08**

Appendix C | *Best Practices in Complaints Investigations*

"Since no two complaints will generally be identical, each investigation is likely to be unique. Despite the differences in the content of individual investigations, all investigations share the same basic structure and follow the same basic processes. The core elements of an investigation apply irrespective of the nature or subject matter of the investigation."

New South Wales ombudsman

"Investigations must be conducted within the framework of the legislation and applicable policies, and with consideration given to the procedural fairness requirements determined by the specific circumstances of the case. Important practices include choosing a competent investigator, establishing a clear mandate for the investigator, keeping an accurate file, preparing an investigation plan and completing a clear, well-reasoned investigation report which will allow...for a fair and informed decision.."

Public Service Commission of Canada

Introduction

This document emerged from the suggestions, findings, and recommendations of the Patient Care Quality Review Boards for enhancing the quality of complaints investigations. To support their effort, the Ministry of Health used the boards' comments to guide a review of current literature and best practices for investigating complaints.

These best practices may be used to support care quality complaints investigations, whether at the health authority or board level. They may also be used to support the review of investigations conducted on behalf of patients and clients. This is a living document—as research and practice in complaints management grow, this best practices document should evolve to reflect them.

Using the Best Practices

This document sets out six principles of complaints investigation based on best practices. Each principle includes considerations for investigators and reviewers to support comprehensive, sensitive, and effective investigations into patient and client concerns.

A complaints investigation is only one part of broader complaints management processes. Specifically, complaints investigation entails collecting and analyzing relevant information (for example, by interviewing those directly involved, reviewing related records and policy documents, or conducting site inspections) to understand decisions, clarify the situation, find any underlying causes, and determine if a complaint can be resolved and care quality improved for the future.

The key element of a good investigation is that it is appropriate to the complaint which prompts it. As such, not every consideration will apply to every investigation. These best practices are intended to provide a common framework for approaching and assessing complaints investigations—they are a way of thinking about the rigor, equitability, and quality of the investigative process.

Because care quality complaints can cover a broad range of concerns, investigations often differ depending on the nature of the complaint (for example, the appropriate channels for gathering information or the breadth of information collected). While each investigation is unique, the principles that guide good investigative practice in general remain consistent. Each principle is a key component of high quality complaints investigations.

The ultimate goal of these principles is to support provincial consistency by bringing best practices together into a single reference document. Ideally, patient and client complaints are treated with the upmost confidentiality, and the investigative process itself is ethical, fair, thorough, responsive, and transparent across British Columbia.

PRINCIPLES	CONSIDERATIONS FOR INVESTIGATORS
Confidential ***Protect personal information.***	▸ Handle personal information securely: » Keep information (e.g. the case file, related documentation, and recordings) in a secure location with access restricted to authorized people who require it to do their job. » Ensure personal information is collected only by authorized people who require it to do their job. ▸ Disclose information only when this is necessary to the investigation. ▸ Ensure that a confidentiality agreement is documented and followed by every investigator. Explain to parties how their personal information will be used. ▸ Ensure that the complainant or representative is authorized to receive confidential information if they are not the client.
Ethical ***Be sensitive to the unique needs of individual parties and minimize the risk of unintended consequences to their lives.***	▸ Identify and minimize the risk of unintended consequences (e.g. emotional, financial) for parties as a result of the investigation. ▸ Ensure that all interaction (e.g. written and verbal responses, interviews, and meetings) is: » Respectful and professional. » Clear and empathetic. » Culturally and religiously sensitive. ▸ Make resources available (particularly in an interview setting) wherever appropriate. For example: » Debriefing /counselling for parties contacted concerning emotionally loaded cases. » Information for parties about recourse for harassment due to their participation. » Help navigating the investigation process and/or expressing concerns. ▸ Get and document informed consent for written statements, interviews, confidential information, expert opinion, etc. Ensure it is signed by any relevant parties. ▸ Tell parties about: » Confidentiality. » Their rights and resources. » Investigation procedures. » What could happen as a result of the investigation.

PRINCIPLES	CONSIDERATIONS FOR INVESTIGATORS
Fair ***Conduct investigations impartially and with procedural fairness.***	▸ Follow due process. ▸ Proceed without making social or cultural assumptions. ▸ Give everyone involved a chance to explain their perspective. ▸ Consider all in-scope complaints and all relevant submissions. ▸ Ensure that no investigator has a conflict of interest. ▸ Discuss and document a plan of investigation with the complainant. ▸ Clearly outline and adhere to the 'standards of proof' for each case (i.e. how much evidence will be required for definitive proof and why that standard is appropriate to that case). ▸ Ensure that the findings of the investigation clearly and logically support the resolution.
Responsive ***Ensure that investigations are timely, communication flows consistently, and support is readily available.***	▸ Notify relevant parties about risks immediately. ▸ Expedite cases as appropriate. ▸ Discuss timelines with those directly affected by the complaint, and outline them in the investigation plan. Communicate regularly with all parties to avoid uncertainty. ▸ Identify potential delays at the outset, and take steps to mitigate them. ▸ Discuss all changes to timelines with the complainant, and document agreement. ▸ Ensure correspondence and responses are clear and flow consistently. ▸ Ensure that information and support are available to those who need it when appropriate. ▸ Emphasize a spirit of joint problem-solving and a focus on resolution. ▸ Ensure that the outcome of the investigation matches the expectations and objectives discussed with the complainant initially—support any differences with clear and logical explanations.

PRINCIPLES	CONSIDERATIONS FOR INVESTIGATORS
Thorough ***Pursue every relevant avenue of inquiry, and obtain corroboration wherever possible.***	▸ Consider all relevant information. ▸ Consider avenues of investigation such as: » Interviews (e.g. with care providers, complainant's family). » Meetings (e.g. between care team and investigator). » Site inspections (e.g. of hospital ward, community care facility). » Documentation (e.g. patient chart, care plan, nursing notes). » Policies and procedures (e.g. guidelines, standards, best practices, staff handbooks). » Expert advice (e.g. clinical committees, medical professionals unrelated to the case). ▸ Obtain original documents whenever possible. ▸ Ensure that written statements are signed and dated by the individuals who make them. ▸ Structure interviews appropriately: » Use interviewers with the right skill set. » Choose a time and an environment which facilitate cooperation. » Outline interview questions in advance and design them to be open-ended (to encourage narratives instead of 'yes' or 'no' answers). » Use 'active listening' skills and double-check information/understanding. » Provide an opportunity for the interviewee to review their answers, correct any misinformation, and/or offer additional information. » Choose face-to-face interaction whenever possible. » Record interviews whenever possible. » When an individual's conduct is in question, interview that person last so that person can respond to questions prompted by previous interviews. » Give interviewees the opportunity to suggest sources for corroboration. » Develop a working knowledge of all policies, procedures, best practices, etc. which are relevant to the case before making the report. ▸ Complete a detailed investigation report. ▸ Have the investigation evaluated by a skilled person other than the investigator (e.g. colleague or supervisor) after the investigation is closed. Identify, discuss, and incorporate any lessons learned into further practice.

PRINCIPLES	CONSIDERATIONS FOR INVESTIGATORS
Transparent ***Communicate investigation procedures clearly to everyone involved. Document investigations accurately and consistently from start to finish.***	▸ Establish the desired outcome, expectations, and objectives of complainants at the outset. Document them and ensure they are managed throughout the process. ▸ Ensure procedures of the investigation are clear and understood by involved parties. ▸ Document every step of the investigation as accurately as possible, including: » Where, when, and how documents are obtained. » The credentials and advice of experts. » The date, time, and circumstances of site inspections. » Transcripts of interviews and meetings, investigator's notes. » Date, time, and nature of correspondence. ▸ Maintain a central investigation file - a complete record of the investigation – for example: » The complaint case report. » The investigation plan. » Signed consent forms. » Evidence collected. » Ongoing documentation (see above). » Responses including reports, updates, correspondence, etc. » Policies, procedures, and best practices related to the case. » The investigation report. » The investigation evaluation. ▸ When an investigation is compromised (e.g. through a breach of confidentiality) deal with it immediately and openly.

Further Information

Patient Care Quality Review Board Act

A copy of the *Patient Care Quality Review Board Act* may be obtained from www.patientcarequalityreviewboard.ca or by calling BC Laws toll-free at 1 866 236-5544.

Contact the Patient Care Quality Review Boards

For more information about the Patient Care Quality Review Boards, or to request a review, please contact:

Patient Care Quality Review Boards
PO Box 9643
Victoria, B.C. V8W 9P1
Toll Free: 1 866 952-2448
Fax: 250 952-2428
Email: contact@patientcarequalityreviewboard.ca

Contact a Patient Care Quality Office

To make a complaint regarding the quality of care that you or a loved one received, please contact the health authority Patient Care Quality Office in your region:

Vancouver Coastal Health
855 West 12th Avenue, CP-380
Vancouver, B.C. V5Z 1M9
Telephone: 1 877 993-9199 (toll-free)
Fax: 604 875-5545
Email: pcqo@vch.ca
Website: www.vch.ca

Vancouver Island Health Authority
Royal Jubilee Hospital
Memorial Pavilion, Watson Wing, Rm 315
1952 Bay Street
Victoria, B.C. V8R 1J8
Telephone: 1 877 977-5797 (toll-free)
Fax: 250 370-8137
Email: patientcarequalityoffice@viha.ca
Website: www.viha.ca

Interior Health
220-1815 Kirschner Road
Kelowna, B.C. V1Y 4N7
Telephone: 1 877 442-2001 (toll-free)
Fax: 250 870-4670
Email: patient.concerns@interiorhealth.ca
Website: www.interiorhealth.ca

Fraser Health
11762 Laity St, 4th floor
Maple Ridge, B.C. V2X 5A3
Telephone: 1 877 880-8823 (toll-free)
Fax: 604 463-1888
Email: pcqoffice@fraserhealth.ca
Website: www.fraserhealth.ca

Northern Health
6th floor, 299 Victoria Street
Prince George, B.C. V2L 5B8
Telephone: 1-877-677-7715 (toll-free)
Fax: 250-565-2640
Email: patientcarequalityoffice@northernhealth.ca
Website: www.northernhealth.ca

Provincial Health Services Authority
(Includes provincial agencies and services such as BC Cancer Agency, BC Renal Agency, BC Transplant, and BC Women's and Children's Hospital)

4th Floor, Women's Health Centre, Room F404
4500 Oak Street
Vancouver, B.C. V6H 3N1
Telephone: 1 888 875-3256 (toll-free)
Fax: 604 875-3813
Email: pcqo@phsa.ca
Website: www.phsa.ca

Notes

Patient Care Quality
Review Boards